

---

From: (b) (6) </o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b)  
To:  
Cc:  
Bcc:  
Subject: Secretary's Stand-Up - OPIA - August 14, 2017  
Date: Mon Aug 14 2017 06:43:49 CDT  
Attachments: 170814\_VA Secretary's Stand-Up Brief.pptx

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Good morning.

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Owner: (b) (6) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)  
Filename: 170814\_VA Secretary's Stand-Up Brief.pptx  
Last Modified: Mon Aug 14 06:43:49 CDT 2017

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# VA Secretary's Stand-Up Brief

14 August 2017

## Executive Summary

National coverage transitioned on Friday from Congress approving a bill on the Appeals process to President Trump signing the Choice and Quality Employment Act on Saturday. The signing was prevalent as a short mention in reports on the Charlottesville events.

Storyline	Outlets	Analysis	Trend	MyVA Priority
President Trump signs Choice Act	<a href="#">AP 1, 2</a> , <a href="#">Stars and Stripes</a> , <a href="#">FOX News</a> , <a href="#">Washington Times</a> , <a href="#">UPI</a> , <a href="#">The Hill</a>	Several quotes from the President's speech at the VA press conference sparked major coverage during the weekend within VA coverage, as well as outside due to Charlottesville. <i>AP 1</i> published the full text of the speech. <i>AP 2</i> was the main piece seen nationwide that was specifically on the six-month Choice extension. The article mentioned the Choice's new budget, the 40-mile rule, and the 28 leases. It also gave space to criticism by CVA's Dan Caldwell on the expense and timing of the bill. <i>Stars and Stripes</i> reported similarly in a more detailed piece. <i>FOX News</i> also interviewed Mr. Caldwell, who said over 90% of Veterans and non-Veterans support having choice. Other national outlets, such as <i>Washington Times</i> and <i>UPI</i> published short summaries. Many outlets connected the signing with Charlottesville, as seen in <i>The Hill</i> .	<b>Emerged</b>	Access
Congress approves bill to improve Appeals process	<a href="#">AP 1, 2</a> , <a href="#">Military.com</a> , <a href="#">Roll Call</a>	<i>AP</i> led Friday coverage with two articles on the Appeals legislation. <i>AP 1</i> was very prevalent nationwide. Few other outlets covered the storyline. <i>Military.com</i> wrote about the legislation as part of its article on the Choice extension.	<b>Emerged</b>	Appeals
Sec. Shulkin: new evidence concerning fmr. DC VMAC director	<a href="#">Washington Times</a> , <a href="#">FOX News</a>	<i>Washington Times</i> summarized Secretary Shulkin's appearance on <i>FOX News</i> where he announced the OIG found "additional concerns" about former Director Brian Hawkins' leadership.	<b>Emerged</b>	Experience
Manchester whistleblower opinion piece	<a href="#">Concord Monitor</a>	<i>Concord Monitor</i> published this first-person account by Dr. Stewart Levenson of Secretary Shulkin's 4 August meeting with whistleblowers.	<b>Emerged</b>	Experience
VVA sues DoD for not protecting privacy records	<a href="#">McClatchy</a>	Outlets nationwide reprinted this article reporting that VVA is suing DoD for "exposing private details of millions of veterans to anybody at all, anonymously, for any purpose." One section of the piece is an outline of VA's history of privacy breaches.	<b>Emerged</b>	Experience
PVA opposes ending dog testing	<a href="#">Stars and Stripes</a>	This article reported on PVA's Executive Director Sherman Gillums speaking out against ending dog testing at VA. Mr. Gillums expressed frustration that the potential medical benefits for Veterans was not raised in debate on the measure.	<b>Emerged</b>	Other

VA-17-0334-A-0000003



# VA Secretary's Stand-Up Brief

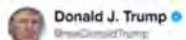
14 August 2017

## Social Media Takeaway

President Trump's tweet on the VA press conference and Charlottesville accounted for over half of Saturday's volume. The remaining weekend activity revolved around Secretary Shulkin and the signing of the Choice Act.

## Key Points

- President Trump's tweet reached a total of 11k RTs since 12 August. A small number of additional users attempted to tie together Charlottesville and VA, with most of these posts receiving little to no traction. @CBSNews' critical [post](#) received the greatest engagement (270+ RTs). @RepublicanChick [tweeted](#) support (250+ RTs). @votevets' [post](#) garnered 190+ RTs.
- The pair of @WhiteHouse tweets on Secretary Shulkin from 10 August were the next most popular. The first (below) reached a total of 1.3k RTs, and the second reached 930+ RTs.
- In three separate posts, @FoxNews tweeted @SecShulkin and included a picture of the Secretary from the day's event. One was an appearance on @foxandfriends and two were quotes from his speech at the signing of the Choice Act. Users engaged very little with these tweets which did not include embedded video or link to related coverage. All garnered between 100+ and 120+ RTs.



Donald J. Trump  
@realDonaldTrump

Am in Bedminster for meetings & press conference on V.A. & all that we have done, and are doing, to make it better-but Charlottesville sad!



Fox News  
@FoxNews

.@SecShulkin on @foxandfriends: We need to build and strengthen the current VA system... We also need to give veterans more choice.



The White House  
@WhiteHouse

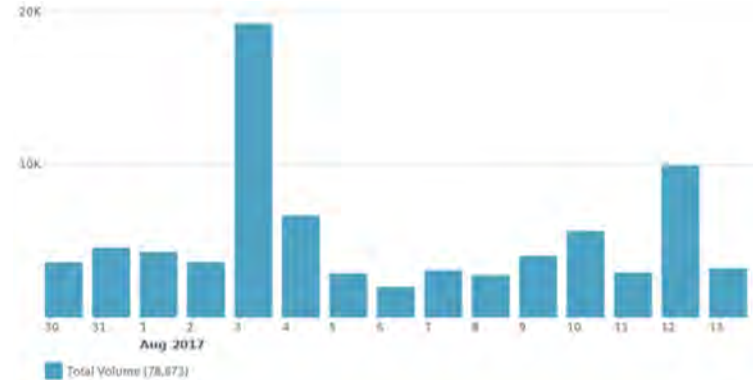
Meet @SecShulkin, Secretary of @DeptVetAffairs.



Fox News  
@FoxNews

.@SecShulkin: "We have authorized over 15 million appointments for veterans."

## Twitter and Facebook Volume: 30 July – 13 August



## Notable Social Media Items

Platform	Item	Relevance
Twitter	Pres. Trump's tweet on Charlottesville	36% of Volume
Twitter	Sec. Shulkin	18% of Volume
Facebook	<a href="#">Shulkin highlights accountability, Veterans Choice at AMVETS</a>	260+ Reactions, 40+ Shares
YouTube	<a href="#">FULL. President Trump Statement on Charlottesville, VA. Pres.Trump to sign Veteran's Affairs Act.</a>	28.7k+ Views

VA-17-0334-A-0000004

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From: Americans for Limited Government  
<media@limitgov.org>  
To: Shulkin, David J., MD  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Cc:  
Bcc:  
Subject: [MARKETING] [EXTERNAL] Trump keeping promises to veterans  
Date: Tue Aug 29 2017 08:41:30 CDT  
Attachments:

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Taking on the VA bureaucracy

August 29, 2017

Permission to republish original op-eds and cartoons granted.

Trump keeping promises to veterans

The Department of Veteran Affairs (VA) was a dark spot in the Obama presidency. The department was plagued with corruption and failed the people who fought for this country, but the efforts of congressional Republicans and President Trump have reversed this trend and expanded care for those who need it most.

Cartoon: Unmasking Soros

The true face behind leftist violence

We Pause to Remark

In case you have not heard it is raining in Texas. It is fascinating to watch the twenty-four-hour news channels try to figure out how many different ways they can say that. It is also interesting to watch them second guess every decision made by the authorities on the ground. Keep in mind these media types have never run anything but their mouths.

Antifa Gets Violent In Berkeley, Attacking Reporters And Trump Supporters

There was a "No to Marxism in America" rally in Berkeley Sunday. Hours later the rally was overrun by Antifa protesters who beat up several people. SF Chronicle reporter Lizzie Johnson captured Antifa harassing a journalist (in the red shirt):

—  
Trump keeping promises to veterans

By Natalia Castro

The Department of Veteran Affairs (VA) was a dark spot in the Obama presidency. The department was plagued with corruption and failed the people who fought for this country, but the efforts of congressional Republicans and President Trump have reversed this trend and expanded care for those who need it most.

President Trump has signed into law the VA Choice and Quality Employment Act of 2017, which dramatically expands choice and opportunity for veterans by authorizing \$2.1 billion in funds for the Veterans Choice Program.

Consistently, veteran's inability to receive access to private sector care has silenced them from making their own medical decisions. But under the Veterans Choice Program, any veteran who lives more than 40 miles from the closest medical facility, has a wait time over 30 days from the clinically indicated date or meets other special criteria will be able to look to the private sector for assisted care.

In states where this has been determinantal to veteran health, the private sector has made a life or death difference already.

Alaska acts as a model for VA Choice. With cities inaccessible by roads and isolated from city centers during winter, Alaska Dispatch News of Sept. 2016 found, by paying private clinics to handle veteran care they could use health care dispatchers in various cities to assist veterans in fixing their care problems directly. Rather than coddling veterans, the choice program empowers them.

With President Trump's expansion of this program, the VA will be better equipped to put veterans first.

The signing comes on the back of four other legislative achievements to assist veterans. The VA Accountability and Whistleblower Protection Act, the Veterans Choice Program Improvement Act, the Increasing the Department of Veterans Affairs Accountability to Veterans Act of 2017, and the Harry W. Colmery Veterans Educational Assistance Act of 2017 all serve to expand veteran benefits and hold the VA accountable for years of corrupt behavior.

Under the Trump Administration, the VA has fired over 500 employees, suspended 200, and demoted 33 to restore the integrity and accountability of the agency. To increase transparency, the VA has become the first agency to post information regarding employee disciplinary action online while maintaining protections for whistleblowers.

To continue expanding care, President Trump has also introduced telehealth services.

Through technological innovation within the department, the VA is now utilizing VA Video Connect to use secure, web enabled video on smartphones and computers to discuss health problems with over 300 VA providers in 67 hospitals. Through the Veteran Appointment Request Applications, veterans will also be able to schedule and modify appointments at anytime from anywhere. A nationwide roll out of the app is expected this year.

Where previous Administrations neglected the needs of our veterans, Congress and President Trump have worked side by side to champion improved care for those who were willing to make the ultimate sacrifice for our country. As Trump understands, if we are not willing to provide adequate care for our countries soldiers, we are failing to care for the country at all.

Natalia Castro is a contributing editor for Americans for Limited Government

## Cartoon: Unmasking Soros

By A.F. Branco

[Click here for a higher resolution image](#)

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We Pause to Remark

By Don Todd

In case you have not heard it is raining in Texas. It is fascinating to watch the twenty-four-hour news channels try to figure out how many different ways they can say that. It is also interesting to watch them second guess every decision made by the authorities on the ground. Keep in mind these media types have never run anything but their mouths.

It is not surprising that the media that was wrong about everything before the election is wrong about everything after the election.

The new slogan of the left, "Peace Through Violence."

First it was Russia, Russia, Russia, then racist, racist, racist, now it is crazy, crazy, crazy. These folks are all singing from the same song book. Makes you wonder who is financing and producing that book.

Hate speech is any speech the Marxist wing of the Democrat Party hates. Mostly that speech is about freedom, individual liberty and limited government.

Not being able to compete with Donald Trump the left has now declared war on an ever-expanding group of dead people. Unlike Trump they cannot reply.

Samuel Adams represents Massachusetts in the Capitol's Statuary Hall. In the interest of more female representation we suggest he be replaced with Mary Jo Kopechne.

Democrats and some Republicans have gone so far out of the mainstream that they have lost sight of the stream all together.

It is amazing that people who have spent their entire lives in elective politics now think that the path to electoral success is to attack the values and mere existence of the sixty percent of the population that is white.

Mitch McConnell now has the lowest approval rating (19%) of any nationally known political figure. True he does not have much to work with in a Senate populated with so-called Republicans the likes of John McCain and the appropriately named Jeff Flake but he is making the worst of it.

If you are in elective office and the New York Times or the Washington Post print something good about

you, you are doing something wrong.

If there is any group of people more disgusting than our establishment political class it is our establishment media class that supports them.

An annual showing of Gone with the Wind has been canceled in Tennessee. The excuse used by the theater is that the movie first shown seventy-eight years ago is suddenly "insensitive." An alternative view is that the movie is dangerous in that it is an accurate view of where we are headed as well as where we have been. Over six hundred thousand Americans lost their lives in our last civil war.

All the Sunday shows this weekend wanted to talk about the pardon of Sheriff Joe Arpaio. Naturally none of them wanted to talk with the Sheriff. Two minutes of Arpaio speaking would have destroyed their entire narrative and they knew it.

Just when you think Speaker Ryan cannot sink any lower he proves you wrong. This time by denouncing the pardon of Sheriff Joe. Karl Rove also joined the leftist chorus. Will Sheriff Clark be the next law enforcement officer to be denounced by the say anything to get approval from the leftist media crowd?

Don Todd is President of Americans for Limited Government Foundation

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ALG Editor's Note: In the following piece from HotAir, John Sexton reports on leftists violence and the lack of police response.

Hotair: Antifa Gets Violent In Berkeley, Attacking Reporters And Trump Supporters

By John Sexton

There was a "No to Marxism in America" rally in Berkeley Sunday. Hours later the rally was overrun by Antifa protesters who beat up several people. SF Chronicle reporter Lizzie Johnson captured Antifa harassing a journalist (in the red shirt):

Another counter-protester went after at KTVU cameraman:

This is not the first time Antifa has targeted reporters. They object to having their faces filmed or photographed because they frequently adopt violent tactics. Another man with a camera was beaten by members of Antifa. He can be seen in this video shot by a news chopper:

Another man was beaten in the street (note: it's not clear who the victim was or why he is described as "alt-right" by this Mother Jones reporter):

At the end of the clip above, you can see a man in a red shirt lying on top of the victim to protect him. You can see more of that in this clip:

Antifa also attacked and beat up a father and son wearing pro-Trump clothing:

Another angle on part of the fight:

Joey Gibson of the group Patriot Prayer showed up at the rally. He was pepper-sprayed and attacked by Antifa:

He retreated behind police lines. There were many reports (like this one) that he had been arrested:

Get the full leftist violent story here.

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[Click here to forward to your friends.](#)

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10332 Main Street #326  
Fairfax, VA 22030

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From: Ulliyot, John </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
To: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Cc: Hutton, James </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>; Wagner, John (Wolf) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Bcc:  
Subject: Statement  
Date: Wed Aug 16 2017 17:14:07 CDT  
Attachments:

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VA's national cemetery system has a long record of balancing history with respecting our fallen Veterans and those who come to honor them.

For example, we do not allow Confederate flags to fly from a fixed pole at our cemeteries, and only allow small Confederate flags to be placed on Confederate soldiers' graves two days a year — on Memorial Day and Confederate Memorial Day.

Monuments to Confederate soldiers stand only in cemeteries where Confederate soldiers are buried or memorialized, and we have no plans to disturb those gravesites or monuments.



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From: Wright, Vivieca (Simpson) </o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b) (5)  
To: DJS </o=va/ou=exchange administrative  
group (fydibohf23spdlt)/cn=recipients/cn=(b) (6),  
(b) (5)  
Cc:  
Bcc:  
Subject: FW: Trump's ongoing Nazi controversies overtake GI Bill expansion signing  
Date: Wed Aug 16 2017 17:21:51 CDT  
Attachments:

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-----Original Message-----

From: Blackburn, Scott R.  
Sent: Wednesday, August 16, 2017 6:20 PM  
To: Wright, Vivieca (Simpson)  
Subject: Trump's ongoing Nazi controversies overtake GI Bill expansion signing

First article I've seen about David's press conference

<http://www.militarytimes.com/news/pentagon-congress/2017/08/16/trumps-ongoing-nazi-controversies-overtake-gi-bill-expansion-signing/>

---

From: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (6)>  
To: (b) (6) @hotmail.com>  
Cc:  
Bcc:  
Subject: FW: Trump's ongoing Nazi controversies overtake GI Bill expansion signing  
Date: Wed Aug 16 2017 17:33:19 CDT  
Attachments:

---

Sent with Good (www.good.com)

-----Original Message-----

From: Wright, Vivieca (Simpson)  
Sent: Wednesday, August 16, 2017 06:21 PM Eastern Standard Time  
To: DJS  
Subject: FW: Trump's ongoing Nazi controversies overtake GI Bill expansion signing

-----Original Message-----

From: Blackburn, Scott R.  
Sent: Wednesday, August 16, 2017 6:20 PM  
To: Wright, Vivieca (Simpson)  
Subject: Trump's ongoing Nazi controversies overtake GI Bill expansion signing

First article I've seen about David's press conference

<http://www.militarytimes.com/news/pentagon-congress/2017/08/16/trumps-ongoing-nazi-controversies-overtake-gi-bill-expansion-signing/>

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From: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>  
To: Wright, Vivieca (Simpson) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6)>  
Cc:  
Bcc:  
Subject: FW: SecVA Schedule - Thursday, August 17, 2017  
Date: Wed Aug 16 2017 18:23:35 CDT  
Attachments:

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Not worth a fight

Sent with Good (www.good.com)

-----Original Message-----

From: Ulliyot, John  
Sent: Wednesday, August 16, 2017 07:12 PM Eastern Standard Time  
To: Wright, Vivieca (Simpson); Hutton, James; Tallman, Gary; DJS  
Cc: (b) (6) Leinenkugel, Jake  
Subject: RE: SecVA Schedule - Thursday, August 17, 2017

+ Jake

Thanks Vivieca -- I don't think a murder board is needed as SecVA is absolutely on message about Charlottesville (he and I talked before and after his Bedminster news conference), but I recommend canceling tomorrow's morning meeting so he can go straight to the WH for his interview.

I will meet him there.

Thanks,

John U.

Sent with Good (www.good.com)

-----Original Message-----

From: Wright, Vivieca (Simpson)  
Sent: Wednesday, August 16, 2017 06:58 PM Eastern Standard Time  
To: Ulliyot, John; Hutton, James; Tallman, Gary; DJS  
Cc: (b) (6)  
Subject: FW: SecVA Schedule - Thursday, August 17, 2017

John listened to the Secretary's Bedminster interview today --many questions about the Charlottesville event. I am sure this will continue during his two media events. If the Secretary is agreeable, we should have a "murder board" in the morning instead of morning report. We can move the agenda

items to Friday. Thoughts?

SecVA Schedule – Thursday, August 17, 2017

8:15 AM En route to White House

8:30 AM - 8:45 AM Media Interview w/David Brody, CBN re: Choice -- White House Press Briefing Room

8:45 AM - 9:00 AM En route to VACO

9:06 AM - 9:20 AM Fox Radio Interview w/Dagen McDowell re: Choice & Modernization -- SecVA Suite-  
we call (212) 938-(b)(6)

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From: Wright, Vivieca (Simpson) </o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b) (5)>  
To: DJS </o=va/ou=exchange administrative  
group (fydibohf23spdlt)/cn=recipients/cn=(b) (6),  
(b) (5)>  
Cc:  
Bcc:  
Subject: Vandalism, Camp Chase Confederate Cemetery, OH  
Date: Tue Aug 22 2017 09:48:05 CDT  
Attachments:

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FYSA

-----Original Message-----

From: (b) (6) (NCA)  
Sent: Tuesday, August 22, 2017 10:12 AM Eastern Standard Time  
To: Wright, Vivieca (Simpson); Blackburn, Scott R.  
Cc: Ulyot, John; Walters, Ronald  
Subject: Vandalism, Camp Chase Confederate Cemetery, OH

Ma'am and Sir –

As you may be aware, we experienced vandalism at NCA's Camp Chase Confederate Cemetery last night. Apparently, a trespasser toppled the historic Confederate soldier statue from the ceremonial arch and removed its head. An article, published just moments ago may be found here: <http://nbc4i.com/2017/08/22/statue-vandalized-at-camp-chase-confederate-cemetery-in-west-columbus/>. Dayton National Cemetery staff are on the way to the cemetery now (which is a closed to interments) to meet with local police to assess damage to the statue and determine next steps. Last week, we requested local police increase their patrols of the cemetery based on the events in Charlottesville and else. Based on this vandalism, we are meeting with OSLE at 11AM and determine whether we need to place 24 hour security at some of our historic sites.

Mr. Ulyot - We will continue to ensure (b) (6) on your staff has the lead on responses to any media queries so they can work up the chain.

As background, the Confederates buried in the cemetery were held by union forces as prisoners of war during the Civil War. By the mid 1890's, efforts began to mark the graves of the Confederate dead within Camp Chase Confederate Cemetery. Led by William H. Knauss, a wounded Union veteran, this movement succeeded in bringing together both Union and Confederate veterans organizations to pay tribute to those interred in the cemetery. In 1904, Congress allocated funds for the maintenance of Camp Chase Confederate Cemetery. Officially, there is an estimate of 2,168 remains in 2,122 gravesites in Camp Chase Confederate Cemetery.

Ron is on leave but engaged on the issue and we will continue to keep you informed.

Thank you,

(b)  
(6)

(b) (6)

Chief of Staff

National Cemetery Administration

Washington, D.C.

202.461. (b)  
(6)

“Discover Their Story; Honor Their Sacrifice”

Learn more @ Veterans Legacy Program

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From: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
To: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Cc:  
Bcc:  
Subject: RE: Thank you  
Date: Thu Aug 17 2017 20:43:19 CDT  
Attachments:

---

Thank you (b) (6)

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6)  
Sent: Thursday, August 17, 2017 03:40 PM Eastern Standard Time  
To: Shulkin, David J., MD  
Subject: Thank you

Dear Honorable Dr. David Shulkin,

My name is (b) (6) MD. I am the son of Coptic Egyptian immigrants who came to this county in the late 60's to escape religious persecution and discrimination.

I was born and raised in New Jersey and have always had a tremendous love and appreciation for this beautiful country and what it has provided for my family.

I was unable to join the military, so I did the next best thing and joined the Veterans' Administration to serve those who fought for freedom, democracy, and the great values of the United States of America. I was very disappointed by the recent events in Charlottesville, Virginia. What I found even more disturbing was to see one of our veterans of the 82nd Airborne Division standing with a Nazi salute. This has created great angst and disappointment for myself, my Jewish colleagues, and other minority colleagues who work diligently side by side every day to serve our veterans. I am cognizant of our Hippocratic oath "I will use treatment to help the sick according to my ability and judgment...." I and others will continue to honor our Hippocratic oath to treat all veterans, even though a few may harbor evil hatred views toward us. I would like to bring to your attention it's not only a few veterans that harbor these views, but some employees at the VAMC also have these sick views. I have worked at four VAMCs and can share with you the stories of discrimination that I and others have dealt with. I truly appreciate and commend you for standing up for honorable values and morality. <http://www.jta.org/2017/08/17/news-opinion/politics/va-secretary-david-shulkin-says-charlottesville-rally-dishonored-veterans>.

We look forward to your continued leadership and guidance in fulfilling President Lincoln's mission statement consistent with the VAMC core values.

Thank you for your service,

(b) (6) MD FACP



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From: Americans for Limited Government  
<media@limitgov.org>  
To: Shulkin, David J., MD  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Cc:  
Bcc:  
Subject: [MARKETING] [EXTERNAL] Rejection of mob rule and return to nation's founding principles of all people created equal the key to reconciliation  
Date: Thu Aug 17 2017 11:45:31 CDT  
Attachments:

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Must recognize how nation got to where we are

For Immediate Release

Contact: Robert Romano

August 17, 2017

Phone: 703-383-0880 ext. 101

Rejection of mob rule and return to nation's founding principles of all people created equal the key to reconciliation

August 17, 2017, Fairfax, Va.—Americans for Limited Government President Rick Manning today issued the following statement urging national reconciliation:

"Yesterday there was a moving memorial for Heather Heyer who tragically died while exercising her First Amendment rights.

"Unfortunately, mobs in some of our cities have taken to vandalizing various statues in an attempt to erase our nation's history. If those in Congress who identify with this new mob rule are truly determined to make a statement, they should start by renaming the Richard Russell Senate Office Building, given Russell's long history as a segregationist who opposed extending civil rights. When they're done wiping his name from the Senate office building, they can change the Byrd Rule, as nothing more than the legacy of former leader of the KKK. To leave Robert Byrd's legacy in place in light of his horrifying views would be counter to the whims of the mob that they wish to marry themselves to.

"Obviously, this kind of symbolism will not bring Heyer back to life or achieve any reconciliation. In fact, all of these symbols remind everyone that many of our leaders have served honorably and yet had checkered histories, and erasing them from our nation's memory does a disservice to the challenges that our nation faces moving forward. The genius of America is that we are a nation of laws founded around a basic recognition that all people are flawed. However the reason for the Bill of Rights was to ensure that flawed people did not impose their wills on others, by protecting individual rights from mob rule. It is around the principle of all people being created equal that our nation needs to rally and from there reconciliation can finally become a reality.

"If we cannot recognize to how we got to where we are, we will never recognize how to get to where we need to be."

To view online: <http://getliberty.org/2017/08/rejection-of-mob-rule-and-return-to-nations-founding->

principles-of-all-people-created-equal-the-key-to-reconciliation/

Interview Availability: Please contact Americans for Limited Government at 703-383-0880 ext. 100 or at [media@limitgov.org](mailto:media@limitgov.org) to arrange an interview with ALG experts.

###

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10332 Main Street #326  
Fairfax, VA 22030

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From: (b) (6) . </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5) >  
To: Shulkin, David J., MD  
</o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)  
Cc: Lee, Jennifer S. (VACO)  
</o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)  
Bcc:  
Subject: Proposed Wrongful Termination from (b) (6) Against a Disabled American Veteran, (b) (6)  
Date: Sat Aug 19 2017 00:35:40 CDT  
Attachments: Audio (b) (6) MD Attempted Removal of a DAV- (b) (6) .m4a  
Letter- (b) (6) \_08.18.2017.pdf

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Dear Secretary David Shulkin,

As a follow up to my last email to you, I have attached another detailed letter and an audio recording of the meeting where (b) (6) issued me a letter of proposed removal (largely based on lies and twists of truth) and told me he was working to terminate me from VA employment within 7 business days. The surprise meeting was August 16, 2017.

I have been very patient trying to solve this at the lowest level possible to no avail in VA thus far. All the way up through my chain of command below you, as well as EEO, and Peter O'Rourke.

Ultimately, I would think based on the enclosed letter, audio recording, and likely other things you know, you could terminate him, (b) (6), from VA employment immediately. I strongly suggest that you do so. His behavior is so very wrong from a VA perspective against a disabled Veteran.

I am fully prepared to go outside of VA with this issue and utilize all resources available to expose this if necessary. I list some of my affiliations below and Congress and the media are always options.

I again thank you for all of the good work you do for our Veterans. Please help me with this, I can no longer do this on my own, it has been seriously affecting my health.

In humility, honor, and service,

(b) (6)

Lifetime full member, DAV  
Lifetime full member, VFW  
US Army, Retired  
Air Force Husband  
Dad of a 12 and 14 year old  
Grandson of two WWII Veterans (1 US/ 1 Canadian; deceased)  
Nephew and cousin of several Veterans  
Brother of over 21 million living Veterans, 9million living VHA enrollees, and all honorable VA employees  
VA OAA Advanced Fellowship graduate, 2-year, Pittsburgh, PA  
Lifetime Patron member of the oldest US Civil Rights organization, the NRA  
Member, Society of Behavioral Medicine  
Lifetime Member of the Penn State Alumni Association  
Member, University at Buffalo Alumni Association

Alumnus, American Military University  
ACLJ Member  
[This qualifies me beyond words that ICARE]

(b) (6), PhD, MPH  
Health Science Officer  
Health Services Research & Development  
US Department of Veterans Affairs  
810 Vermont Avenue NW (10P9H)  
Washington, DC 20420

Office: (202) 443-(b) (6)  
Work mobile: (202) 870-(b) (6)  
Email: (b) (6)@va.gov

-----Original Message-----

From: (b) (6)  
Sent: Thursday, August 17, 2017 07:37 PM Eastern Standard Time  
To: Shulkin, David J., MD  
Cc: Lee, Jennifer S. (VACO)  
Subject: VA Liability, Risk, and Harsh Treatment of a Disable Veteran Employee

Dear Secretary David Shulkin,

I have used my chain of command below you to no avail given I have been issued a letter of proposed removal from VA employment with 7 business days notice of my termination (letter dated August 16, 2017). The reasons are largely based on lies and corrupt behavior from reasonably bad managers in VHA's HSRD (10P9H) (b) (6), MD, (b) (6), PhD, (b) (6), PhD).

I filed a formal EEO complaint on June 7, 2016, which was finally assigned an investigator yesterday, August 16, 2017 based on an email I received. I emailed Peter O'Rourke July 10, 2017 and around that time some things happened that seemed to address this for a time. However, it would seem by appearances at this point that it was just more time for the bad managers and VA to build a bigger case against me, a disabled Veteran trying to serve my fellow Veterans and VA employees.

One major issue that warrants your attention at this point, and they have tried to shut down over the past several months, is related to faith, religion, and spirituality in VA. There exists a major VA liability and risk to our Veterans along with a potential opportunity if reversed.

I am a disabled Veteran, working as a Scientific Program Manager in VA HSRD with a PhD in Community Health and Health Behavior, and managing such portfolios as Complementary and Integrative Health, Post Deployment Health, Gulf War Illness, and lead on health behavior change projects.

Without your office's prompt action, I will have to go outside of VA for assistance and will pursue all avenues including VSOs I am a lifetime member of, other organizations I am a member of, Congress, the media, and retain an attorney to move through the court system. I cannot keep this up on my own, and I cannot continue to fight them, the bad managers and all the VA resources they are bringing

against me, still do my job, and be there for my family. This is also seriously affecting my health and has been for several months, largely due the stress of the injustice and the extra frustrations and time consuming nature of HSRD management's foolishness.

I have countless email records and other documents that contain their lies and other corrupt behavior towards me and many conversations have been recorded that written statements against me clearly lie about. These records do not contain confidential or classified material, just simply a record of lying, corrupt managers in action against a disabled Veteran and VA employee. I can't believe this has been allowed to go on in VA. I do believe they, and not me, are the type of people you are trying to remove from VA.

Enclosed is a more formal letter with two enclosures outlining the major points. I also Cced Jennifer Lee as she is someone I trust on this and should serve well to advise on it.

I very much appreciate your consideration of these matters. Could you or one of your direct representatives intervene to address this and stop this onslaught against me, transparently to me? Is anyone in VA leadership truly on the side of disabled Veterans? This is one of my last efforts to determine this and you seem like someone that is on the side of Veterans.

In humility with honor in service,

(b)  
(6)

[REDACTED] PhD, MPH  
Health Science Officer  
Health Services Research & Development  
US Department of Veterans Affairs  
810 Vermont Avenue NW (10P9H)  
Washington, DC 20420

Office: (202) 443-(b)  
Work mobile: (202) 870-(b)  
Email: (b) (6) @va.gov

---

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)  
/cn=recipients/cn=(b) (6), (b) (5)  
Filename: Audio-(b) (6) MD Attempted Removal of a DAV-(b) (6) m4a  
Last Modified: Sat Aug 19 00:35:40 CDT 2017

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Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)  
/cn=recipients/cn=(b) (6), (b) (5) >  
Filename: Letter (b) (6) \_08.18.2017.pdf  
Last Modified: Sat Aug 19 00:35:40 CDT 2017

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**DEPARTMENT OF VETERANS AFFAIRS**  
**Veterans Health Administration**  
**Washington DC 20420**

August 18, 2017

Secretary David J. Shulkin, MD  
U.S. Department of Veterans Affairs  
810 Vermont Avenue, NW  
Washington, DC 20420

Subject: Proposed Wrongful Termination from (b) (6) Against a Disabled American Veteran, (b) (6)

Dear Secretary David Shulkin,

(b) (6), MD issued me a letter of proposed removal and told me he was working to terminate me from VA employment within 7 business days. I am a disabled Veteran and the meeting was Wednesday morning 08.16.2017 at 7:42am in my office at 1100 first street NE. I am going directly to you because I have been addressing this for months to those below you, including my chain of command, Peter O'Rourke, and EEO, to no avail given what happened on August 16, 2017. I have attached an audio recording of the meeting. I have been recording meetings for a while now since they (HSRD management) have continue to bully me, lie, and come against me with negative personnel actions for a year now, even escalating considerably after I contacted the EEO office.

About 10-15 minutes prior to them coming into my office, the HSRD Administrative Officer, (b) (6), stopped by and said (b) (6) needed me to sign a form related to my annual performance review. I told her that I would not sign it and that Rachel herself had told me not to sign documents associated with that in a prior meeting and that others in VA had advised me not to sign these things and that I was following their advice. (b) (6) said she thought that was odd and left my office.

Then, (b) (6) and (b) (6) (Director of ORD Operations) came into my office very swiftly, seemingly trying to startle me, catch me by surprise, likely an attempt to try and provoke me at 7:42am, kicking the book out from under the door I use to deter its shutting, and they proceeded to shut the door even with me assertively telling them not to in the moment directly. I've also had a note on the door for a month that the door will remain open for transparency, after shutting it they would not open it when I said I would leave if they did not open it, and it has been clear that I would not meet with (b) (6) without Rachel Ramoni present for over month now. I then got up and opened the door and walked out, only agreeing to come back in and meet with them because I saw someone I could trust on my way out whom I invited to be in the meeting, a fellow Veteran and fellow man of God. HSRD Management's tactics are extremely confrontational, especially so among military or Veterans. These tactics are actually highly trained out of military to use on each other, in part because these are the kind of tactics we are trained to use on our enemies. It would seem that (b) (6) and (b) (6) are trying to play a part that they have no idea how to play, it's extremely concerning, and has no place in VA.

My door 100% always open policy, with me never shutting or allowing it shut since I've been in my office is in part because of the bullying and gossip they and others do behind closed doors, verbally, in email, and other documents, and they lie and twist about conversations and emails and use it to coerce employees to go along with them even when they lie. The open door is also a figurative supportive model of transparency in all reasonable ways.

In the meeting, (b) (6) told me he doesn't have "any choice" but to terminate me because, "We're an organization [VA] of laws and rules and these are the things that I'm (b) (6) following," and, "Frankly, they [employees] would refuse to follow me (b) (6) if I didn't take action here. I'm doing this for the good of our unit and all of ORD."

However, all of (b) (6)' reasons to terminate me are largely based on lies, twists of truth, and at no point have I violated any true law or VA policy. However, he and his subordinate managers (b) (6) and (b) (6) as well as (b) (6) have violated VA policy, lied about policy, and that is in part why they have come so hard against me because they are trying to bully me out to protect themselves from truth and justice. (b) (6) also suggested that I have had past major problems in my career where I had done things wrong, yet I have had a stellar career (as noted on the attached audio recording to the email this was sent with).

They (b) (6), and (b) (6) substantially abuse and elevate their positions of power and authority. David even did it in the meeting where he told me, a disabled Veteran enrolled in VA healthcare, that I'm not allowed to come to any VA facility, including not 810 Vermont, even with me being a patient in VA, which he well knows. They have also bullied me in the past to try and keep me from going higher in the chain of command before and they have only gotten dramatically worse after I filed an official EEO complaint against them on June 7th, 2017.

It further could be very traumatic in the short or longer term for some of my fellow VA employees to see me terminated from VA employment or bullied out of the Office of Research and Development. This is due to the lies and games at least some of them have observed from management in my work unit and things I have shared since I've been in HSRD as part of the VA cultural transformation process through increased awareness such as difficult experiences for persons of various races, ethnicities, and faiths throughout history (E.g., Native Americans, African Americans, Armenians, Jews, Christians, Muslims, Hindus, Buddhists, Atheists, both PRC and ROC China) as well as those who have stood up for them such as Martin Luther King and ultimately about serving our fellow VA employees and Veterans better through our work. My fellow employees in my work unit, and likely throughout ORD, also are all aware that I have an active EEO complaint filed against (b) (6) (b) (6), and (b) (6).

Multiple employees have come to me over the last several months telling me things they are observing or being told by management that they feel are wrong, but asked me not to say anything internally because they are concerned of reprisal from management or even losing their jobs. I have also spoken with a few past employees that have told me similar things. I even saved a contractor from being fired, but they pulled her away from me and later bullied her out, with her resigning a couple months later.

Especially concerning is that I was first removed from the office temporarily 2 months ago by 3 armed Department of Homeland security officers, in front of my office colleagues, and during a wrongful suspension and with them falsely telling others I have mental illness; it parallels a Nazi Germany scenario.

They're trying to stigmatize me as the, "crazy, suicidal Vet, zealot that may hurt someone, so he must be removed for their safety," as they continue to harass me, try to undermine me, even taking my pay through holding my standard promotion, wrongful suspension, wrongful AWOL, and have so far failed at preventing me from doing my job with all of these tactics. What they are doing is wrong, so very wrong it's hard to believe it's actually happening in real life, in year 2017 America against a disabled Veteran in VA, by an MD and two PhD psychologists.

A parallel is if an MD and two PhD psychologist managers at the Autism Association did this to an employee with Autism who didn't do anything reasonably wrong. Or two teachers and a principal did this to a student. The way they (b) (6) and (b) (6) moved quickly into my office, kicked the book out from the door, shut it against my requests and even me assertively directing them not to in the moment gives me a feel for what doctors used to do to psychiatric patients years ago with drugging, strait jackets, and forced lobotomies.

Their behavior is not okay. It is the antithesis of VA's ICARE values especially given they are doing this against a disabled Veteran whose wife is currently deployed to the Middle East as an Air Force Psychologist. I am confident the media would have an honest figurative field day with this. Especially given (b) (6) is using my forced absence to keep me away from the meetings next week that will ultimately decide \$15million-\$40million in Veteran research dollars, in part because I have been standing ethically straight against their coercion and mismanagement.

Dr. Secretary, I am confident that with this email and attached audio recording, you have enough evidence to remove (b) (6) from VA employment immediately. Let him try to fight us, we have plenty more evidence, and I also know what the American people's decision would be.

I very strongly suggest you do this as we cannot have corrupt managers like him in VA. I have plenty more evidence via recordings, emails, and otherwise against him, his subordinate managers (b) (6) as well as (b) (6), including them lying and belittling me in meetings, emails, and signed statements. I only started recording conversations after they persisted in lying in meetings and about the meetings as well as persisted with negative and wrongful career threatening actions against me. I have been very patient with them and gave them many ways out. Clearly, they have fallen in the traps they continually tried to set for me.

This has also been substantially negatively affecting my health; I can't keep this up. I cannot continue to resist their attacks against me, do my job, and be there for my wife and children. With my wife deployed, it makes it that much more of a struggle as a lone dad.

I very much appreciate your time, assistance, and all you are doing for my fellow Veterans.

In humility, service, and honor,

(b) (6)

(b) (6), PhD, MPH  
Health Science Officer

Health Services Research and Development Service (10P9H)  
Veterans Health Administration  
U.S. Department of Veterans Affairs

Cf:  
Jennifer S. Lee, MD

Enclosures (to email this was attached to)

1. Audio recording of the meeting where (b) (6) and (b) (6) issued (b) (6) a letter of proposed removal, August 16, 2017 at 7:42am.

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From: Blackburn, Scott R. </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Cc:  
Bcc:  
Subject: Charlottesville / Veterans  
Date: Sat Aug 19 2017 08:33:33 CDT  
Attachments: IMG\_4027.png

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Here are a couple of quick unfortunate articles about the white supremacists and Veteran connections. Unfortunately this is a reality of the armed forces. The military attacks people from all walks of life and some of the 18 year olds that sign up are doing so because they are troubled. Recruiters are often under a lot of pressure to meet quotas so they sometimes turn a blind eye to gang members, supremacists, etc. A positive illustration of what happens next is what (b) (6) writes about it the attached Facebook post. I was very proud to see this happen in my platoon (I had people on both sides of the spectrum...but within a few months we had opened their minds and we became a team...similar to the movie Remember the Titans). Unfortunately that doesn't always happen and you are left with these idiots doing idiot things and giving Veterans a bad name. As you can guess these things (Charlottesville, Timothy McVeigh in the OKC bombing, the DC Area sniper of 2002, other domestic terrorists) are incredibly shameful/embarrassing to the 99% of Veterans that live the values. It is similar to bad apples that we have in the VA that need to be held accountable. Particularly in the younger Veteran community right now (Student Veterans of America, Got Your 6, etc), there is a very somber mood that this BS has overshadowed the GI Bill expansion that otherwise would be celebrated as a very positive thing.

<http://taskandpurpose.com/james-alex-fields-army-charlottesville/>

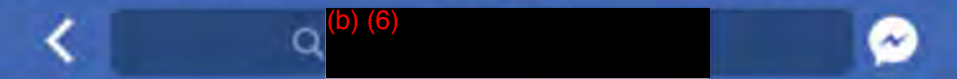
<http://taskandpurpose.com/leader-of-charlottesville-white-nationalist-group-was-a-marine-corps-recruiter/>

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Owner: Blackburn, Scott R. </o=va/ou=exchange administrative group (fydibohf23spdl)  
/cn=recipients/cn=(b) (6), (b) (5)  
Filename: IMG\_4027.png  
Last Modified: Sat Aug 19 08:33:33 CDT 2017

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(b) (6) (b) (6)

Sunday at 12:35 AM ·

Today, I couldn't help but to think about my bunkmate at Marine Corps Recruit Depot Parris Island back in 1990. His name was Private Stephens (never knew his first name), and he had "Proud American" tattooed on the back of his head. He was an unapologetic skinhead. I didn't like him much, and I'm sure he didn't like me. But we were mutually invested in each other's success in finishing recruit training. Our drill instructors had kicked my ass as much as they'd kicked his, literally. My pain was his pain and vice versa (thanks Sergeants (b) (6) and (b) (6)). Misery is a great equalizer on PI. He, as I did, would ultimately exemplify what it meant to truly put God, Corps, and country before self. I eventually trusted him without question because we believed in the same thing — the U.S. Marine code and core values in everything we did. And I would've thrown myself on a grenade to save him and believe he would've done the same for me. I can't explain it. It just is what it is. Most will never know that feeling ... that transcends sociobiographical identity for a higher purpose ... and it's a shame. We need it right now.

You, Bill Rausch and 163 others · 26 Comments · 14 Shares

Like

Comment

Share

(b) (6) (b) (6)

Saturday at 11:08 PM · CNN ·

AMERICAN  
OVERSIGHT

VA-17-0334-A-000083



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From: (b) (6) @columbus.rr.com>  
To: Shulkin, David J., MD  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
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Lucille B. </o=va/ou=visn 05/cn=recipients/cn=(b) (6), (b) (5)>  
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(b) (6) @yahoo.com (b) (6) @yahoo.com>; (b) (6)  
</o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)>  
Bcc:  
Subject: [EXTERNAL] President's Words and OUR VA  
Date: Thu Aug 17 2017 06:33:19 CDT  
Attachments: image001.jpg

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Secretary Dr. Shulkin,

As an American Disabled Veteran and a member of the LGBT community; I was alarmed and sickened when our President spoke in a positive, inclusive, and accepting way about the dark forces of Neo Nazis, White Supremacists, and other such HATE groups. There is no room at the VA for such HATE!

You said it is "a dishonor to our country's veterans for the Nazis and the white supremacists to go unchallenged, and that we all have to speak up about this as Americans." You spoke of your belief in the need to speak up by citing a poem from Protestant pastor Martin Niemöller, a vocal critic of Adolf Hitler who wrote the famous lines beginning with, "First they came for the Socialists."

Dr. Shulkin, so I am speaking up and standing with you against such HATE groups. Such HATE groups cannot be permitted any acceptance or sanctuary within your VA administration – not even an inch!

Please keep our VA open to all Veterans regardless their race, color, religion, sex, and sexual orientation.

Your good friend,

(b) (6)



---

(b) (6) CDR, SC, USNR-R Amputee (BK, Service-Connected)

614-288-(b) (6) (b) (6)@columbus.rr.com Service-Dog (b) (6)

---

Owner: (b) (6) @columbus.rr.com>  
Filename: image001.jpg  
Last Modified: Thu Aug 17 06:33:19 CDT 2017

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image001.jpg for Pr  
Item: 16 ( Attachme  
of 1)

00037



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From: Forbes Healthcare <healthcare@forbes.com>  
To: Shulkin, David J., MD  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Cc:  
Bcc:  
Subject: [MARKETING] [EXTERNAL] Ken Frazier to speak at Forbes Healthcare Summit  
Date: Fri Aug 18 2017 12:15:42 CDT  
Attachments:

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[Register for the Forbes Healthcare Summit](#)

[LEARN MORE ABOUT THE FORBES HEALTHCARE SUMMIT](#)

[VISIT SITE](#)

Dear David,

The Trump news cycle has been particularly heavy this week. In the wake of the President's response to the Charlottesville attack, a speech that left much to be desired in terms of morality, numerous CEOs have stepped down from his economic advisory councils, and among them is the CEO of Merck, Ken Frazier. If you've been keeping up with the news, you'll have read about President Trump's tweetstorm. Here's what you need to know about Ken Frazier.

Ken and many other notable names in healthcare will be returning to speak at the Forbes Healthcare Summit for its 6th annual gathering, taking place November 29-30 in New York City.

RSVP to join your peers in New York for this one-of-a-kind, once-a-year event.

We hope to see you!

[REGISTER NOW](#)

Looking to change your email preferences?  
[Update your preferences.](#)

---

From: (b) (6) <(b) (6)@vva.org>  
To: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (6)>  
Cc:  
Bcc:  
Subject: [EXTERNAL] Fwd: For Immediate Release  
Date: Mon Aug 14 2017 11:53:52 CDT  
Attachments:

---

Sent from my iPhone

Begin forwarded message:

From: VVA Communications Department <mporter@vva.org>  
Date: August 14, 2017 at 11:15:57 AM EDT  
To: (b) (6) <(b) (6)@vva.org>  
Subject: For Immediate Release  
Reply-To: VVA Communications Department <mporter@vva.org>

VVA Condemns Neo-Nazis

[View this email in your browser](#)

IMMEDIATE  
RELEASE  
August 14, 2017                      No. 17-41  
Mokie Porter  
301-996-0901  
mporter@vva.org  
-

Vietnam Veterans of America Condemns Neo-Nazis

(Washington, DC) – Vietnam Veterans of America vociferously condemns neo-nazis, white supremacists, and wanna-be KKKers, whose violent, anti-American tendencies resulted in the death of Ms. Heather Heyer, who was exercising her legitimate Constitutional rights to free speech. It also resulted in the death of Trooper Berke M. M. Bates and Lt. H. Jay Cullen, Virginia State Troopers, who were trying to protect everyone's rights.

"Our parents did not sacrifice during World War II to defeat Nazism in Europe, only to have it return on our shores. When so-called protesters show up in helmets and flack jackets, carrying shields and clubs, they clearly are not planning to peacefully exercise their rights. They are trying to intimidate America, and their bigoted ideology must be resisted by all true patriots," said John Rowan, VVA National President.

"If there are any VVA members who harbor any of these bigoted ideologies, they are encouraged to turn in their membership cards. We did not don the uniform and serve our country to enable the acceptance of intolerance," said Rowan.

Vietnam Veterans of America is the nation's only congressionally chartered veterans' service organization dedicated to the needs of Vietnam-era veterans and their families. VVA's founding principle is "Never again will one generation of veterans abandon another."

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Our mailing address is:

Vietnam Veterans of America, 8719 Colesville Road, Suite 100, Silver Spring, Maryland 20910  
[www.vva.org](http://www.vva.org)

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---

From: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (6)>  
To: (b) (6) <(b) (6)@vva.org>  
Cc:  
Bcc:  
Subject: RE: [EXTERNAL] Fwd: For Immediate Release  
Date: Mon Aug 14 2017 11:56:57 CDT  
Attachments:

---

Good for you!

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6) <(b) (6)@vva.org>  
Sent: Monday, August 14, 2017 12:54 PM Eastern Standard Time  
To: DJS  
Subject: [EXTERNAL] Fwd: For Immediate Release

Sent from my iPhone

Begin forwarded message:

From: VVA Communications Department <mporter@vva.org>  
Date: August 14, 2017 at 11:15:57 AM EDT  
To: (b) (6) <(b) (6)@vva.org>  
Subject: For Immediate Release  
Reply-To: VVA Communications Department <(b) (6)@vva.org>

VVA Condemns Neo-Nazis

[View this email in your browser](#)

IMMEDIATE  
RELEASE  
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Mokie Porter  
301-996-0901  
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-

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---

From: Walters, Ronald </o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6)>  
To: Wright, Vivieca (Simpson) </o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b) (5)>  
Cc: DJS </o=va/ou=exchange administrative  
group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> Blackburn,  
Scott R. </o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> Loren, Donald  
P. </o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>  
Ulliot, John </o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (6)>  
</o=va/ou=visn 09/cn=recipients/cn=(b) (6)>  
Bcc:  
Subject: Springfield National Cemetery Confederate Monument Vandalism  
Date: Wed Aug 30 2017 11:49:33 CDT  
Attachments: 001.jpg  
003.jpg  
005.jpg  
006.jpg

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FYI.

An individual threw red paint on a Confederate monument at VA's Springfield National Cemetery (Illinois) this morning. The statue will be cleaned professionally.

We hired security guards to provide 24-hour surveillance of the monument. (The incident occurred during a shift change or restroom break. We are trying to determine the details so we can adjust the security approach.)

A note was left at the base of the monument by the individual allegedly responsible.

See attached pictures for details.

We will continue to provide a security presence at our most vulnerable cemetery sites.

Ron

John, (b) (6) We may be asked for a statement re: the above. I would suggest a response similar to

the Camp Chase media statement. Thanks.

---

Owner: Walters, Ronald </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6)  
Filename: 001.jpg  
Last Modified: Wed Aug 30 11:49:33 CDT 2017

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Owner: Walters, Ronald </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6)  
Filename: 003.jpg  
Last Modified: Wed Aug 30 11:49:33 CDT 2017

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WE CLAIM THIS ACTION AS WHITE PEOPLE  
WHO REALIZE, BECAUSE IT IS WE WHO  
BENEFIT FROM THE EXPLOITATION AND  
DISPLACEMENT OF MILLIONS OF PEOPLE OF COLOR -  
FROM THE VERY FOUNDING OF THIS COUNTRY  
TO THE PRESENT DAY - THAT IT IS OUR  
RESPONSIBILITY TO DESTROY MONUMENTS  
THAT GLORIFY WHITE SUPREMACY, AND TO DO SO  
IN THE SPIRIT OF SOLIDARITY AND WITH JOY.  
WE URGE OTHERS TO DO THE SAME.



---

Owner: Walters, Ronald </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (7)(F)  
Filename: 005.jpg  
Last Modified: Wed Aug 30 11:49:33 CDT 2017

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TO THE MEMORY OF THE MISSOURI SOLDIER IN THE ARMY  
OF THE  
CONFEDERATE STATES OF AMERICA

MAJOR GENERAL STERLING PRICE

AMERICAN  
OVERSIGHT



---

Owner: Walters, Ronald </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (7)(F)  
Filename: 006.jpg  
Last Modified: Wed Aug 30 11:49:33 CDT 2017

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From: Wright, Vivieca (Simpson) </o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b) (5)>  
To: Ulyot, John </o=va/ou=exchange  
administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> Hutton, James  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>; Tallman, Gary  
</o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)> DJS  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Cc: (b) (6)  
</o=va/ou=visn 10/cn=recipients/cn=(b) (6), (b) (5)> (b) (6)  
</o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)>  
Bcc:  
Subject: FW: SecVA Schedule - Thursday, August 17, 2017  
Date: Wed Aug 16 2017 17:58:04 CDT  
Attachments:

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John listened to the Secretary's Bedminster interview today –many questions about the Charlottesville event. I am sure this will continue during his two media events. If the Secretary is agreeable, we should have a “murder board” in the morning instead of morning report. We can move the agenda items to Friday. Thoughts?

SecVA Schedule – Thursday, August 17, 2017

8:15 AM En route to White House

8:30 AM - 8:45 AM Media Interview w/David Brody, CBN re: Choice -- White House Press Briefing Room

8:45 AM - 9:00 AM En route to VACO

9:06 AM - 9:20 AM Fox Radio Interview w/Dagen McDowell re: Choice & Modernization -- SecVA Suite-  
we call (212) 938-(b) (6)

---

From: Ulliyot, John </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
To: Wright, Vivieca (Simpson) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)> Hutton, James </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>; Tallman, Gary </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)> DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Cc: (b) (6) </o=va/ou=visn 10/cn=recipients/cn=(b) (6), (b) (5)> (b) (6) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)> Leinenkugel, Jake </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Bcc:  
Subject: RE: SecVA Schedule - Thursday, August 17, 2017  
Date: Wed Aug 16 2017 18:12:32 CDT  
Attachments:

---

+ Jake

Thanks Vivieca -- I don't think a murder board is needed as SecVA is absolutely on message about Charlottesville (he and I talked before and after his Bedminster news conference), but I recommend canceling tomorrow's morning meeting so he can go straight to the WH for his interview.

I will meet him there.

Thanks,

John U.

Sent with Good (www.good.com)

-----Original Message-----

From: Wright, Vivieca (Simpson)  
Sent: Wednesday, August 16, 2017 06:58 PM Eastern Standard Time  
To: Ulliyot, John; Hutton, James; Tallman, Gary; DJS  
Cc: (b) (6)  
Subject: FW: SecVA Schedule - Thursday, August 17, 2017

John listened to the Secretary's Bedminster interview today --many questions about the Charlottesville event. I am sure this will continue during his two media events. If the Secretary is agreeable, we should have a "murder board" in the morning instead of morning report. We can move the agenda items to Friday. Thoughts?

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we call (212) 938-(b)

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From: Wright, Vivieca (Simpson) </o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b) (5)>  
To: Ulliyot, John </o=va/ou=exchange  
administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> Hutton, James  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>; Tallman, Gary  
</o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)> DJS  
</o=va/ou=exchange administrative group  
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Cc: (b) (6)>  
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</o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b) (5)> Leinenkugel, Jake  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Bcc:  
Subject: RE: SecVA Schedule - Thursday, August 17, 2017  
Date: Wed Aug 16 2017 19:45:51 CDT  
Attachments:

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Ok

-----Original Message-----

From: Ulliyot, John  
Sent: Wednesday, August 16, 2017 07:12 PM Eastern Standard Time  
To: Wright, Vivieca (Simpson); Hutton, James; Tallman, Gary; DJS  
Cc: (b) (6)> Leinenkugel, Jake  
Subject: RE: SecVA Schedule - Thursday, August 17, 2017

+ Jake

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-----Original Message-----

From: Wright, Vivieca (Simpson)  
Sent: Wednesday, August 16, 2017 06:58 PM Eastern Standard Time  
To: Ulyot, John; Hutton, James; Tallman, Gary; DJS  
Cc: (b) (6)  
Subject: FW: SecVA Schedule - Thursday, August 17, 2017

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From: Wright, Vivieca (Simpson) </o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b) (5)>  
To: Ulliyot, John </o=va/ou=exchange  
administrative group  
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</o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)> DJS  
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Cc: (b) (6)  
</o=va/ou=visn 10/cn=recipients/cn=(b) (6), (b) (5)> (b) (6)  
</o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b) (5)> Leinenkugel, Jake  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Bcc:  
Subject: RE: SecVA Schedule - Thursday, August 17, 2017  
Date: Wed Aug 16 2017 19:47:55 CDT  
Attachments:

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No murder board but will keep morning meeting.

-----Original Message-----

From: Wright, Vivieca (Simpson)  
Sent: Wednesday, August 16, 2017 08:45 PM Eastern Standard Time  
To: Ulliyot, John; Hutton, James; Tallman, Gary; DJS  
Cc: (b) (6) Leinenkugel, Jake  
Subject: RE: SecVA Schedule - Thursday, August 17, 2017

Ok

-----Original Message-----

From: Ulliyot, John  
Sent: Wednesday, August 16, 2017 07:12 PM Eastern Standard Time  
To: Wright, Vivieca (Simpson); Hutton, James; Tallman, Gary; DJS  
Cc: (b) (6) Leinenkugel, Jake  
Subject: RE: SecVA Schedule - Thursday, August 17, 2017

+ Jake

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John U.

Sent with Good (www.good.com)

-----Original Message-----

From: Wright, Vivieca (Simpson)

Sent: Wednesday, August 16, 2017 06:58 PM Eastern Standard Time

To: Ulliyot, John; Hutton, James; Tallman, Gary; DJS

Cc: (b) (6)

Subject: FW: SecVA Schedule - Thursday, August 17, 2017

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From: Americans for Limited Government  
<media@limitgov.org>  
To: Shulkin, David J., MD  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Cc:  
Bcc:  
Subject: [EXTERNAL] Trump pushes corporate, individual tax cuts to restore U.S.  
competitiveness and the boost working class, but where's Congress?  
Date: Thu Aug 31 2017 08:58:54 CDT  
Attachments:

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When will Congress get into the game?

August 31, 2017

Permission to republish original op-eds and cartoons granted.

Trump pushes corporate, individual tax cuts to restore U.S. competitiveness and the boost working class, but where's Congress?

President Trump is pushing for tax reform, but Congress is nowhere to be found. What Republican runs for Congress saying they're against tax cuts?

Never let a crisis go to waste

President Obama's first Chief of Staff in the White House, now Mayor of the war zone Chicago, famously said, "You never let a serious crisis go to waste. And what I mean by that it's an opportunity to do things you think you could not do before." People are still being rescued from homes in Houston, and the storm is continuing to do damage to Louisiana, Mississippi, Alabama, and the Florida panhandle, but the mainstream media and the Church of Manmade Climate Change cannot help themselves.

The Morning Call: Pro-Trump groups plan Allentown rally against Charlie Dent

Two national conservative groups upset with U.S. Rep. Charlie Dent's criticism of President Donald Trump plan a rally Friday in Allentown, the moderate Republican's hometown.

Fox News: Pelosi condemns Antifa violence in Berkeley after criticism

Thirteen people were arrested and five others were injured Sunday after more than 100 black-clad, hooded protesters with masks and weapons attacked and overwhelmed the peaceful demonstrators.

---

Trump pushes corporate, individual tax cuts to restore U.S. competitiveness and the boost working class, but where's Congress?

By Robert Romano

In his bid to restore U.S. competitiveness in the global economy, President Donald Trump announced his proposals for tax reform before a crowd in Springfield, Mo. on Aug. 30, arguing that the American people and particularly American businesses are overtaxed.

In true Trump form, he made his appeal on the grounds that help working class Americans and boost the economy.

Calling for the corporate tax rate to be cut to 15 percent, Trump said, “Foreign companies have more than a 60 percent tax advantage over American companies. They can pay their workers more, sell their products and services at lower costs and still make more money than their U.S. competitors.”

As a result, Trump argued that the high cost of doing business in the U.S. had contributed to the outsourcing of jobs overseas, and that lowering business taxes would help bring jobs back. “We cannot restore our wealth if we continue to put our business at such a tremendous disadvantage. We must reduce the tax rate on American businesses so they keep jobs in America, create jobs in America and compete for workers right here in America — the America we love.”

In addition, Trump called for tax cuts for individuals as well as incentivizing trillions of dollars of repatriation of foreign earnings by American companies.

It’s a big vision, and it is up to Congress to work on the details, Americans for Limited Government President Rick Manning said after the speech: “Now it is up to Congress to step up to the plate and get [the] comprehensive tax reform that President Trump has called for done.”

Trump appeared mindful of the challenge on Capitol Hill ahead of him — as well as the opportunity to act. This only the third time in since the Great Depression that Republicans have had the White House, House, and the Senate at the same time.

“[T]his is our once-in-a-generation opportunity to deliver real tax reform for everyday hardworking Americans, and I am fully committed to working with Congress to get this job done,” Trump said, adding coyly, “And I don’t want to be disappointed by Congress, do you understand me?”

There, the failure to get an Obamacare repeal done this year — failing by one vote in the Senate — remains fresh in Trump’s memory as it should and he’s not letting it go away.

Tax reform stands then as a golden opportunity for redemption by the GOP Congress.

The American people are well aware that Trump would sign all of these bills on Obamacare, on taxes, on infrastructure, and on the wall. They know what the obstacle is. It’s not Trump. It’s Congress.

In that context, it is hard not to view the Republican Congress’ pointless inaction as simply a petty, childish rebuke of the Trump presidency. Jealousy. It’s about making the President look bad so they can say, “We told you so” — when they’re actually the real problem.

To stop him from succeeding, even if it means hurting America. Is that what the American people voted for in 2016? Or did they want jobs?

As American for Limited Government’s Manning noted, “Far too many Americans are being left behind and not a part of the labor force. President Trump’s tax reform proposal will generate massive investment in the U.S. with the result being increased opportunities for our nation’s workers to regain their footing as they seek to achieve the American dream.”

That is what is truly at stake with tax reform. But does Republican Congress even get it? Can they even

articulate a lower-tax, pro-growth message anymore?

Just to be sure: There was a president every in the 1980s named Ronald Reagan. He cut taxes even though Democrats controlled the House. Look it up. You might learn a thing or two. Like, for example, how it led to one of the biggest jobs booms in modern economic history.

At the end of the day, making America competitive again really is about making America great again. And if the Republican Congress cannot get behind that their president on that unifying message, then it's not merely time to question their party loyalty. It's time to question their patriotism and love of country.

Otherwise, if obstructing the Trump agenda is the way the GOP Congress wants to run its 2018 re-election, so be it. But here is this once in a lifetime opportunity to do tax reform. President Trump is teeing it up for them. This should be real easy. What Republican runs for Congress saying they're against tax cuts?

Robert Romano is the Vice President of Public Policy at Americans for Limited Government.

---

Never let a crisis go to waste

By Printus LeBlanc

President Obama's first Chief of Staff in the White House, now Mayor of the war zone Chicago, famously said, "You never let a serious crisis go to waste. And what I mean by that it's an opportunity to do things you think you could not do before." People are still being rescued from homes in Houston, and the storm is continuing to do damage to Louisiana, Mississippi, Alabama, and the Florida panhandle, but the mainstream media and the Church of Manmade Climate Change cannot help themselves.

When climate events like major snow storms that cancel climate change meetings or ice flows stall climate change research ships, they call it weather. When a hurricane hits Houston, they want to call it man-made climate change. You cannot have it both ways.

For anyone that has ever lived within 100 miles of a coast, they know hurricanes are a normal occurrence in the Atlantic, Caribbean, and Gulf of Mexico. The "experts" might not know this, but there is actually a season for hurricanes that runs between June and late November, with the most intense storms happening in August and September.

The notion that Harvey was caused by man-made climate change is laughable at best, and fraudulent science at worst. What evidence is there to prove what the networks are reporting? Keep in mind, the National Oceanic and Atmospheric Administration (NOAA) only has measurable data for hurricanes beginning in 1851. The amount of data needed to claim hurricanes are getting stronger is immense and the amount of data scientists have is infinitesimally small.

However, there is data on the strength of hurricanes for the last 170 years. There is a direct correlation between the barometric pressure in the eye of a storm and the wind speed. The lower the pressure, the tighter the eye, and the higher the wind speeds.

The lowest pressure on record for an Atlantic hurricane belonged to Wilma, a storm in 2005 with a barometric pressure of 882 millibars. The tenth storm on the list had a pressure of 910 millibars. Hurricane Harvey doesn't even come close, with a barometric pressure of 938 millibars.

What about wind strength? Hurricane strength is also measured by wind strength. Surely man-made climate change caused Hurricane Harvey to have the strongest wind speed on record. Once again, the church of man-made climate change would be wrong.

In 1980, Hurricane Allen recorded the highest sustained wind speed ever in the Atlantic Ocean at 190 mph. The second highest wind speed ever recorded was the 1935 "Labor Day" hurricane at 185 mph. Once again, as strong and intense as Hurricane Harvey was, it had a maximum sustained wind speed of 130 mph, nowhere near the top 50.

Let's try another method. How about inches of rain per hour? If man-made climate change caused Hurricane Harvey to be stronger than normal, then the rainfall per hour would be astronomical.

Harvey had around 3.5 inches of rain per hour at its maximum. Do not disregard the number, that is a tremendous amount of rainfall, but it is nowhere near the upper echelon of inches of rain per hour. An unnamed Florida hurricane dropped 6 inches per hour in 1947, while Tropical Storm Rosa was at 5 inches per hour in 1994. Once again, Hurricane Harvey is not abnormal for the data that is available.

Hurricane Harvey was not the result of man-made climate change. A high-pressure system over the southwestern U.S. prevented the storm from doing what hurricanes do, move and drop rain. The high-pressure system stalled the "dirty" side of the storm over Houston. So, as Houston is getting hit by the dirty side of the storm, the "clean" side is recharging over the Gulf of Mexico while the high-pressure system is stopping the storm from moving, keeping Houston on the "dirty" side of the storm for days. By the way, high-pressure systems in the desert southwest of the U.S. is kind of normal during the summer.

Because the storm was partially situated over the Gulf of Mexico while it was stalled, it created an extended tidal surge. Tidal surges are another normal byproduct of hurricanes. However, the tidal surge did not allow the Houston rainwater drainage system to properly work, because the rain water was draining into the space the tidal surge was occupying. It is kind of hard for Houston rain water to drain into the Gulf of Mexico, while Harvey is trying to push the Gulf of Mexico into Houston.

People are still in danger and the mainstream media believes it is its duty to push a narrative given to them by their progressive masters. If the mainstream media can see clear to stop pushing the Church of Manmade Climate Change and learn how to use google, they would see the truth, and perhaps gain a small amount of respect back from the citizens that distrust them so much.

Printus LeBlanc is a contributing reporter for Americans for Limited Government

ALG Editor's Note: In the following piece from The Morning Call, Tom Shortell details a rally being held in Allentown PA, to let the Tuesday Group know they need to help President Trump pass the agenda they voted for.

The Morning Call: Pro-Trump groups plan Allentown rally against Charlie Dent

By Tom Shortell

Two national conservative groups upset with U.S. Rep. Charlie Dent's criticism of President Donald

Trump plan a rally Friday in Allentown, the moderate Republican's hometown.

Americans for Limited Government and Phyllis Schlafly's American Eagles hope to raise voter awareness of Dent's public breaks with Trump and his administration. They plan similar events nationwide, targeting lawmakers they see as not supporting the president.

Meanwhile, local efforts to recruit challengers are already underway, and one potential candidate stepped forward Tuesday.

Dent and others are "surrendering the Trump agenda to [House Speaker] Nancy Pelosi and the far left," Rick Manning, president of Americans for Limited Government, said Tuesday in a statement. "We urge all Trump supporters to join us ... and send a message to Congress to get to work and pass President Trump's agenda."

Schafly was a lawyer and a conservative icon who opposed feminism and abortion, but is best known for helping defeat an Equal Rights Amendment to the U.S. Constitution. She died last year.

Dent, 57, a co-leader of a group of moderate House Republicans, has criticized Trump for his travel ban on those from predominately Muslim countries, for firing James Comey as the FBI director was investigating the administration, for blaming the violence in Charlottesville, Va., on "both sides," and for failing to take a leading role in the efforts to replace and repeal Obamacare.

Last year, Dent called on Trump to quit the presidential campaign after leaked video footage caught Trump boasting about groping women.

"We will stand up there and say, 'Are Charlie Dent's positions in line with the working people of Allentown?'" said Ed Martin, president of Eagle Forum Education.

Get the full story [here](#).

---

ALG Editor's Note: In the following piece from Fox News, Samuel Chamberlain describes the liberal groups turning on Antifa for its violence:

Fox News: Pelosi condemns Antifa violence in Berkeley after criticism

By Samuel Chamberlain

House Minority Leader Nancy Pelosi, D-Calif., condemned attacks by members of Antifa against conservative demonstrators over the weekend in Berkeley, Calif., calling the violence a "sad event."

"Our democracy has no room for inciting violence or endangering the public, no matter the ideology of those who commit such acts," Pelosi said in a statement Tuesday evening. "The violent actions of people calling themselves antifa [sic] in Berkeley this weekend deserve unequivocal condemnation, and the perpetrators should be arrested and prosecuted."

Thirteen people were arrested and five others were injured Sunday after more than 100 black-clad, hooded protesters with masks and weapons attacked and overwhelmed the peaceful demonstrators.

"They came with black masks, they carried weapons, they were pounding people down with their fists

and feet," University of California-Berkeley College Republican Ashton Whitty told Fox News' "The Story with Martha MacCallum" Monday night. "I knew I had to get out of there."

"Everything was great until Antifa showed up," Whitty added.

"In California, as across all of our great nation, we have deep reverence for the Constitutional right to peaceful dissent and free speech," Pelosi's statement continued. "Non-violence is fundamental to that right. Let us use this sad event to reaffirm that we must never fight hate with hate, and to remember the values of peace, openness and justice that represent the best of America."

Pelosi, who represents a district in neighboring San Francisco, had been criticized for not condemning the Antifa violence as forcefully as she had warned about the potential for unrest at a Patriot Prayer rally that had been planned for Saturday.

Get the full story [here](#).

---

Subscribe in a reader

American for Limited Government  
10332 Main Street # 326  
Fairfax Virginia 22030  
United States

This email is intended for david.shulkin@va.gov.  
[Update your preferences](#) or [Unsubscribe](#)

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From: (b) (6) . </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5) >  
To: Shulkin, David J., MD  
</o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)  
Cc: Lee, Jennifer S. (VACO)  
</o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)  
Bcc:  
Subject: FYSA- FW: Wrongful Call and Action Initiated by Rachel and (b) (6)  
Date: Mon Aug 28 2017 12:38:56 CDT  
Attachments: July 2017-Rachel call about (b) (6).m4a  
RE-Your recent message.pdf  
RE: Follow-up (3).msg  
RE: For Your Wellbeing--Honorable VA ORD Employees (4).msg  
image001.jpg  
image002.png  
image003.png

---

FYSA

From: (b) (6)  
Sent: Monday, August 28, 2017 1:38 PM  
To: Beck, Lucille B.; Alaigh, Poonam, M.D.  
Subject: FW: Wrongful Call and Action Initiated by Rachel and (b) (6)

Hi Lu and Poonam,

The issue with management in VHA ORD/HSRD continues to escalate. They continue to attempt to cover up their lies, bullying, and corruption in continued escalation against me, a disabled Veteran, with their latest actions being them threatening me officially with imminent termination of my VA employment (official letter from (b) (6) was on August 16, 2017). Lu, I have not heard back from you through this process, so I am addressing this to my next level in the chain of command to Poonam Alaigh, MD.

Lu, I received the attached email response from (b) (6) suggesting I am to send you something official by the end of the week, September 1, 2017; however, I have yet to hear back from you over the past week since this has been elevated to your level.

Poonam, over the past year these corrupt managers have continued to lie and twist the truth against me (and others) because I will not go along with their corruption. See some of the latest example of their attacks against me in the latest email enclosed below to Lu. Also, in the thread attached that (b) (6) (b) (6) replied to ("For Your Wellbeing—Honorable VA..."), I had addressed matters with my colleagues



because of the persistent promulgation and slandering against me behind my back by these managers, essentially them trying to destroy my career because I would not go along with them and their corruption. I had also forwarded my prior email to Lu on Friday right after I sent it.

I am a disabled Veteran with my wife currently deployed to the Middle East for the Air Force, making this especially egregious.

Lu and Poonam, Can we set up a brief conference call to discuss this transparently among the three of us tomorrow, Tuesday August 28, 2017?

In honor and service,

(b)  
(6)

(b) (6), PhD, MPH

Health Science Officer

Health Services Research & Development

US Department of Veterans Affairs

810 Vermont Avenue NW (10P9H)

Washington, DC 20420

Office: (202) 443-(b)  
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Email: (b) (6)@va.gov

[Note. I normally do not include the below in my signature but thought it important for you to see. This qualifies me beyond words that ICARE, about a lot of things, and loyal to honorable people, family, and organizations. These are just a portion of my active affiliations/labels]

Lifetime full member, DAV

Lifetime full member, VFW

US Army, Retired

Air Force Spouse to an Air Force Psychologist currently deployed to the Middle East

Dad of a 12 and 14 year old

Grandson of two WWII Veterans (1 US/ 1 Canadian)

Nephew and cousin of several Veterans

Brother of over 21-million living Veterans and all honorable VA employees

Brother of 9-million living VHA enrollees with me being a 50% service connected VHA enrolled patient (due to physical injuries in the military)

VA OAA Advanced Fellowship graduate

From: (b) (6)  
Sent: Thursday, August 24, 2017 8:19 AM  
To: Beck, Lucille B.  
Subject: Wrongful Call and Action Initiated by Rachel and (b) (6)

Hi Lu,

In my brief meeting with you in June, I could tell that you're a decisive, strong leader who understands tough issues. Those named in this email below are not and do not.

It is clear that Rachelle Ramoni is in league with (b) (6) and (b) (6) in efforts to cover their wrongful figurative tracks. They are coming against one of the few disabled Veterans in all of ORD, the only one in HSRD, and the only one standing up firmly in ORD to really work to solve these problems rather than do as the aforementioned perpetrators do and just pretend like they care (They are clearly the figurative wolves in sheep's clothing, at best for Rachel, she is just naïve and incompetent; In transparency: I am a shepherd).

As a note, in regular operations, I do not send long emails; I rather do not like them. However, in these emails I am trying to ensure people such as yourself have the information they need to ideally do what is right more promptly.

As an outline of the below and attached:

-Rachel Ramoni lacks the fortitude, integrity, or competence to be in a leadership position in VA. She is either extremely naïve or very corrupt and dangerous.

-Rachel (or her authorized representative) wrongfully reported to DHS Law Enforcement Officers I was sending her harassing emails (you, Lucille, were included on all of the emails and I still trusted Rachel as part of my honorable chain of command when I sent them).

-This is not retaliation on my part, we simply cannot afford to have people like her in leadership positions given the gravity of the VA employee health and Veteran health situation (nor (b) (6), (b) (6), or (b) (6)).

-I am a disabled Veteran and this is our VA (Veterans and honorable VA employees).

Yesterday (231633AUG2017), I received a wrongful phone call from the Department of Homeland Security's Federal Protective Services (FPS) on my personal cell phone. The DHS Officer said that he received a call from VA 1100 First Street that I was sending "harassing emails" to employees at that location; I clarified that I had sent no harassing emails, only emails to my chain of command. He then verified that the only emails he saw were the ones I sent to Rachel Ramoni (all of which you, Lucille, were Cced on), he also verified, that in context he saw nothing harassing about them and simply said to me not to send any more emails to Rachel, rather only to you, Lucille Beck.

This is extremely wrongful treatment of me to have a Department of Homeland Security (DHS) Officer contact me with a false accusation of harassment, especially in context of (b) (6) lying to DHS/FPS previously to instigate them against me aggressively to bully me out of the office.

I attached an audio excerpt from a phone call last month where Rachel expressed that me simply sharing truth in attempts to promote transparency, awareness, and forward movement is unnerving to her and gives her concern of my ability to work in ORD. She also notes that she urged me to rely on the EEO process, yet that can take years and they are costing me thousands of dollars via my prior suspension, a wrongful AWOL, holding my standard promotion from GS-13 to GS-14, and censor and gag me from helping to solve real Veterans' health problems. She also chastises that I got my new PIV card on schedule and went higher in my change of command, despite the persistent harsh treatment of me in ORD/HSRD. Rachel then alludes that you, Lu Beck, have already passed judgement against me, that a simple question I asked for efficiency being inappropriate (my question to promote efficiency in our conversation with faith-relevance). She then closes alluding that it was wrong for me to be out of the office for a period where I needed sick leave for space from their harassment and their games as well as I had vacation and other time planned with my children while their mother was out of the country and wrongfully says I did not request leave "appropriately" for part of that time. At no point have I done anything truly wrong, yet they continue to bombard me and others with their foolishness, wasting extensive government personnel resources.

For more context, view this video of Martin Luther King Jr.'s response to white pastors criticizing him for going too far too fast and we all know he was extremely attacked for standing up for others: <https://www.youtube.com/watch?v=C0KPs8VssX0&sns=em>. Please also read this sermon transcript, "when peace becomes obnoxious" where MLK states, "In a very profound passage which has been often misunderstood, Jesus utters this: He says, 'Think not that I am come to bring peace. I come not to bring peace but a sword.' Certainly, He is not saying that He comes not to bring peace in the higher sense. What He is saying is: 'I come not to bring this peace of escapism, this peace that fails to confront the real issues of life, the peace that makes for stagnant complacency,'" [http://kingencyclopedia.stanford.edu/encyclopedia/documentsentry/when\\_peace\\_becomes\\_obnoxious\\_sermon\\_delivered\\_on\\_18\\_march\\_1956.1.html](http://kingencyclopedia.stanford.edu/encyclopedia/documentsentry/when_peace_becomes_obnoxious_sermon_delivered_on_18_march_1956.1.html). Of further relevance is current Attorney General Jeff Sessions's speech to attorney's with comments on MLK, <http://thefederalist.com/2017/07/13/heres-the-speech-jeff-sessions-delivered-to-christian-first-amendment-lawyers/>

Now, insert my comments in relation to Veterans as a Veteran. I am much aligned with MLK and other honorable leaders in this nation, past and present. VA ORD, and possibly you yourself Lu Beck according to Rachel, are saying that I as a disabled Veteran am inappropriate and possibly lacking the ability to work in VA as a disabled Veteran in a work unit (HSRD) full of non-Veterans except for me and one other prior employee who had served part-time in the Marine reserves (technically not a Federal statute Veteran). Please also see the attached email thread where (b) (6) highly disrespects me in a very argumentative way and says I do MLK a "disservice" in aligning myself with him, MLK. These attacks and comments would be fine for the public to do against me or my fellow Veterans in their rights; however, in VA, their dishonorable behavior is not acceptable toward a disabled Veteran.

In a prior incident after a June 12, 2017 meeting with Rachel Ramoni, Rachel called me on my cell phone later that afternoon and falsely said that I told her in our meeting that I was contemplating suicide and that she was worried about me; to which I responded that was false (I have the full meeting audio recorded). She then followed up in the attached email thread, "RE: Follow-up." I responded and have continued to attempt to work with Rachel in honorable support; however, she instead merely continues to support the wrongful, deceitful effort against me.

It is now clear to me that Rachel, along with (b) (6) does not have a level of understanding, honor, integrity, or respect to serve in a leadership position in VA where we are working to reduce major concerns such as Veteran suicide, opioid addiction and other substance abuse/overdose, and promote true wellbeing. Rachel is a new 2017 addition to the problem of why we have not been making progress on these issues in VA.

I know this is a lot of information via email; however, I assure you, this me actually trying to support you in efficiency as I know these perpetrators (Rachel Ramoni, (b) (6) ) are hurting VA, VA employees, and Veterans; you can remove them decisively now. This has been costing VA a ton of money and time even in the brief 2.5-month period I have been addressing this to your level and causing me a ton of undue stress and pain, reaching serious levels several months ago this past January, 2017. Moreover, rather than keeping the figurative peace that they think they are, they actually create more tension through their foolish games (b) (6), and (b) (6) games and Rachel Ramoni's now clear support of their games, whether by it be by Rachel's naiveté or maliciousness).

No employee should be retained in VA that comes persistently against a disabled Veteran like this in VA, especially not an MD's, PhD Psychologists, or a DMD ScD in a leadership or otherwise power or authority position. They are not walking even close to the ICARE values. For this persistent bad behavior, they should be immediately suspended and removed from VA service and barred from all Federal service.

I am giving you this evidence in this efficient manner so you may act more decisively and swiftly to remove the persons the VA I believe in (with ICARE Values) is trying to cleanse itself of. That is, rather than me wait to share this through a very large singular document that will take a ton of time to develop and others to review, by these emails with most relevant recent information, including audio recordings,

you can act swiftly and decisively to help me and remove the figurative “bad guys”.

In honor and service,

(b)  
(6)

[REDACTED], PhD, MPH

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50% Service-Connected Disabled Veteran Enrolled in VA Healthcare as a Patient

Lifetime Patron member of the oldest US Civil Rights organization, the NRA

Member, Society of Behavioral Medicine

Lifetime Member of the Penn State Alumni Association

ACLJ Member

From: (b) (6) P.  
Sent: Wednesday, August 23, 2017 10:56 AM  
To: Ramoni, Rachel; Beck, Lucille B.  
Subject: [Email 4 of 4, audio 3 of 3]- (b) (6) False, Slanderous, Statements Against a Disabled Veteran

Email 4 of 4, audio 3 of 3.

There is much more than this going back to at least last November 2016 with (b) (6) and over a year ago with (b) (6), and (b) (6) between audio, emails, and other documents. What they promulgate against others who don't go along with them and the time it takes everyone is horrendous; this is serious personnel fraud, wasted, and abuse to levels of millions of dollars in their collective tenure in ORD alone I am sure. This doesn't event get into the bias and corruption associated with the \$600,000,000+ ORD oversees annually of taxpayer dollars aimed to help our Veterans through research.

From: (b) (6)  
Sent: Wednesday, August 23, 2017 10:47 AM  
To: Ramoni, Rachel; Beck, Lucille B.  
Subject: [Email 3 of 4, audio 2 of 3]- (b) (6) False, Slanderous, Statements Against a Disabled Veteran

Email 3 of 4, audio 2 of 3

From: (b) (6) P.  
Sent: Wednesday, August 23, 2017 10:45 AM  
To: Ramoni, Rachel; Beck, Lucille B.  
Subject: [Email 2 of 4, audio 1 of 3]- (b) (6) False, Slanderous, Statements Against a Disabled Veteran

Email 2 of 4, audio 1 of 3

From: (b) (6)  
Sent: Wednesday, August 23, 2017 10:43 AM  
To: Ramoni, Rachel; Beck, Lucille B.  
Subject: [Email 1 of 4, False Statements]- (b) (6) False, Slanderous, Statements Against a Disabled Veteran

Hi again Rachel and Lu,

I have enclosed an example of (b) (6) false, slanderous statements against me, (b) (6) a VA ORD employee and disabled Veteran (50% Service Connected enrolled in VA Healthcare as a patient). As you will see in reading (b) (6) official signed statement from 06.14.2017 about her account from 06.08.2017, my notes written on it, and from listening to the actual audio of the meeting, (b) (6) makes several false statements and twists it into a slanderous official account against me. Furthermore, (b) (6) had requested the meeting with me after (b) (6) and (b) (6); I essentially (b) (6) asked (b) (6) to be a part of this meeting. I also requested that (b) (6) and (b) (6) be a part of the meeting given they have been witnesses to much of this, but (b) (6) would not allow it. This is email 1 of 4 due to file size, with subsequent emails containing the audio from the meeting.

In this June 8, 2017 meeting with (b) (6) and (b) (6), I shared major concerns about wrongful actions against me, a disabled Veteran working in VA, that are heinous in context. However, in her statement behind my back she says in gossip-like tone that it was a "rant" about how (b) (6) and (b) (6) were "out to get him". Even worse, she has a level of character and values that she clearly thinks this behavior of hers is okay to a level of putting this wording in an official signed statement.

Is this how leaders are supposed to operate in VA? Does this exhibit trust and the ICARE Value behavior? Should leaders like this be allowed to remain in VA Service? The answer is: No.

Thus, on further consideration from my emailed stance yesterday, I move farther in my recommendation towards (b) (6). Not only that she needs immediately suspended and removed from ORD service, she needs removed from VA service. We do not need people like her to be around for even one more day to try and finish things up, yet risk liability of their further damage and fraud, waste, and abuse of taxpayer dollars and the honorable employees funded by them. At this point in her career and level of entrenched contradiction to VA ICARE values, (b) (6) cannot be rehabilitated in VA nor the Federal Government.

With this statement and audio alone, it is clear (b) (6) should not be working in a supervisory capacity or position of any real power or authority in VA. Her behavior against a disabled Veteran employee is the antithesis of VA's ICARE values. Furthermore, it is this very behavior that drives our Veterans and others to commit suicide, especially when no one listens to and dismisses the Veteran or employee being attacked.

This is far from retaliation by me or others. We simply cannot afford the liability of people like (b) (6) serving in VA.

(b) (6), however, has acted very professionally throughout my limited interactions with him in this situation that (b) (6) and (b) (6) wrongfully pulled him into. This may likely be a result of the professionalism he was trained in the Army.

I highly recommend that not a single vacancy gets filled or detailed in ORD by anyone who is not a Veteran until we are staffed at least 1/3 Veteran, which is aligned with the VA overall goal of having VA be 1/3 Veteran. This will help a positive cultural transformation in ORD very swiftly, and I can help with that.

In honor and service,

(b) (6)

(b) (6), PhD, MPH

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US Department of Veterans Affairs

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US Army, Retired

Air Force Spouse

Dad of a 12 and 14 year old

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Nephew and cousin of several Veterans

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50% Service-Connected Disabled Veteran Enrolled in VA Healthcare as a Patient

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Member, Society of Behavioral Medicine

Lifetime Member of the Penn State Alumni Association

ACLJ Member

From: (b) (6)  
Sent: Tuesday, August 22, 2017 12:01 PM  
To: Ramoni, Rachel  
Cc: Beck, Lucille B.  
Subject: Email 3 of 3- More information- (b) (6) audio 06.08.2017

Clip of (b) (6) following (b) (6) back to his desk (Email 3 of 3).

Rachel and Lu,

This was from a meeting called by (b) (6) with me to "touch base". She called the meeting the day before (June 7, 2017), after she found out that I had officially filed an EEO complaint. (b) (6) had also surprised me the day before, with him coming into the office sick, after him finding out about my formal EEO complaint filing and informed me of an unpaid suspension he had been planning for me to now start 3 business days later (clear reprisal timing).

In the June 8, 2017 meeting, (b) (6) then surprised me to tell me she was revoking my telework (more reprisal). I made very clear in the meeting I was not going to endure any more emotional abuse from her, told her I did not want to talk to her anymore at that time given she kept persisting trying to discuss

things I did not want to talk about, and I left her office. She then followed me back to my desk, continued to heckle me, even using the Lord's name in vain at one point in mockery of me and threatening to call security on me. Even though the word "security" trails off and is hard to make out, in (b) (6) own follow-up written statement she said she then went to (b) (6) office to try and call security.

The worst part of this incident, is (b) (6), and (b) (6) all have tried to turn this around on me in their attempt to label me as the crazy, unprofessional one. Me simply raising my voice slightly for her to "get away" from me is quite minor and not wrong at all, especially given she continued to heckle me and after a year of their games. (b) (6) behavior was very wrong by VA standards, as has been the rest of their behavior. (b) (6) even said it was wrong and that she would make sure (b) (6) and (b) (6) did not succeed in turning this around on me (on a separate audio to me); however, (b) (6) subsequent words, in writing and verbally, as well as actions were very different.

I am here to serve and not play games with these dishonorable people. Again, no one is perfect, but they have clearly crossed major lines against a disabled Veteran doing his best in VA service for his fellow Veterans, honorable VA employees, and our families.

I again, strongly recommend removing them from VA immediately. You have more than enough evidence. Between these clips and all of the other documents you have.

In honor and service,

(b) (6)

From: (b) (6)  
Sent: Tuesday, August 22, 2017 11:38 AM  
To: Ramoni, Rachel  
Cc: Beck, Lucille B.  
Subject: Email 2 of 3- More information-(b) (6) audio 03.06.2017

Clip 2 of 2 on (b) (6) badgering (b) (6) in counseling (Email 2 of 3).

From: (b) (6)  
Sent: Tuesday, August 22, 2017 11:36 AM  
To: Ramoni, Rachel  
Cc: Beck, Lucille B.  
Subject: More information-(b) (6) audio 03.06.2017 (email 1 of 3)

Hi Rachel and Lu,

I thought I'd send an example (attached audio) that may be of interest to you as you address this, given (b) (6), and (b) (6) have been working diligently behind my back to undermine me for over a year now. They persist in trying to stigmatize me as the unprofessional one and that my conduct is unbecoming a Federal employee as I work to promote transparency, respect for all persons, ICARE values, and Military and Veteran cultural competence, which are all parts of our work and VA guidance. I do this as the lone disabled Veteran in HSRD (50% service connected and enrolled in VA healthcare). They have further tried to promulgate the image that I am the "crazy religious Vet with mental health issues." I do not have mental illness, and if I did, their attacks would be considered that much worse.

You have more than enough evidence already to remove them from VA (b) (6) as well as (b) (6) and (b) (6) from leadership positions and out of ORD. This would stop this huge waste of federal resources on the part of retaining the perpetrators in ORD or VA. They can try to attack VA all they want legally, but a couple audio clips, emails, and other documents we have alone against 50% service connected disabled Veteran would be more than enough VA defense in any honorable courtroom.

I attached the audio associated with the March 6, 2017 counseling by (b) (6) (Clip 1 of 2 for file size) as well as in a subsequent email of the audio of her harassing me back to my desk on June 8, 2017. In the March meeting (b) (6) essentially badgers and interrupts me for 20 minutes, the 1 or 2 times it may seem like I am interrupting her is simply me continuing on past her interruptions. There are further points where I continue without acknowledging her jabs and where I change my speaking as I respond to her nonverbal communication. Essentially, throughout the meeting she was directing at me frowns, eye rolling, cackling laughs, shaking her head and sneering. Verbally you can also hear her general belittling tone and sarcasm. This is especially conduct unbecoming a Federal Employee in a leadership role as well as other employees they model this behavior to.

Of course no one is perfect, and it greatly pains me to be in a position to have to share this type of thing. However, it is also my responsibility as a Health Science Officer in VA to add this transparency and stand up for Veterans, fellow VA employees, and their families. This includes even standing up for myself and for my deployed Air Force spouse, a psychologist, and our children, as I stand up for others.

The major problem here is their repeated use of falsehoods, drama, and bullying behavior, a lot of it, and far too much for persons in their level of power, authority, and potential negative influence. Even worse, they are clearly doing it against one of our disabled Veterans doing his best to serve honorably in VA, me. Sadly, they are trying to amass all the VA resources they can against me, and so far, they, the deceptive bullies working against the Veteran, are winning. This is not the game they think it is, this is real life, these are taxpayer dollars, we are the VA with a clear mission—to care for our Veterans and their families. It is not to care for VA employees that hurt Veterans and other VA employees.

One way I think about this situation is, how would the American people view this conversation (among many others and emails and more, there's a lot worse than this...). This is not a threat by any means, this is me exhibiting one analytical thinking approach to try and protect people and VA, ultimately in service to our Nation's Veterans.

In honor and service,

(b)  
(6)

[REDACTED], PhD, MPH

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Owner: (b) (6) . </o=va/ou=exchange administrative group (fydibohf23spdlt)  
/cn=recipients/cn=(b) (6), (b) (5) >  
Filename: July 2017-Rachel call about (b) (6).m4a  
Last Modified: Mon Aug 28 12:38:56 CDT 2017

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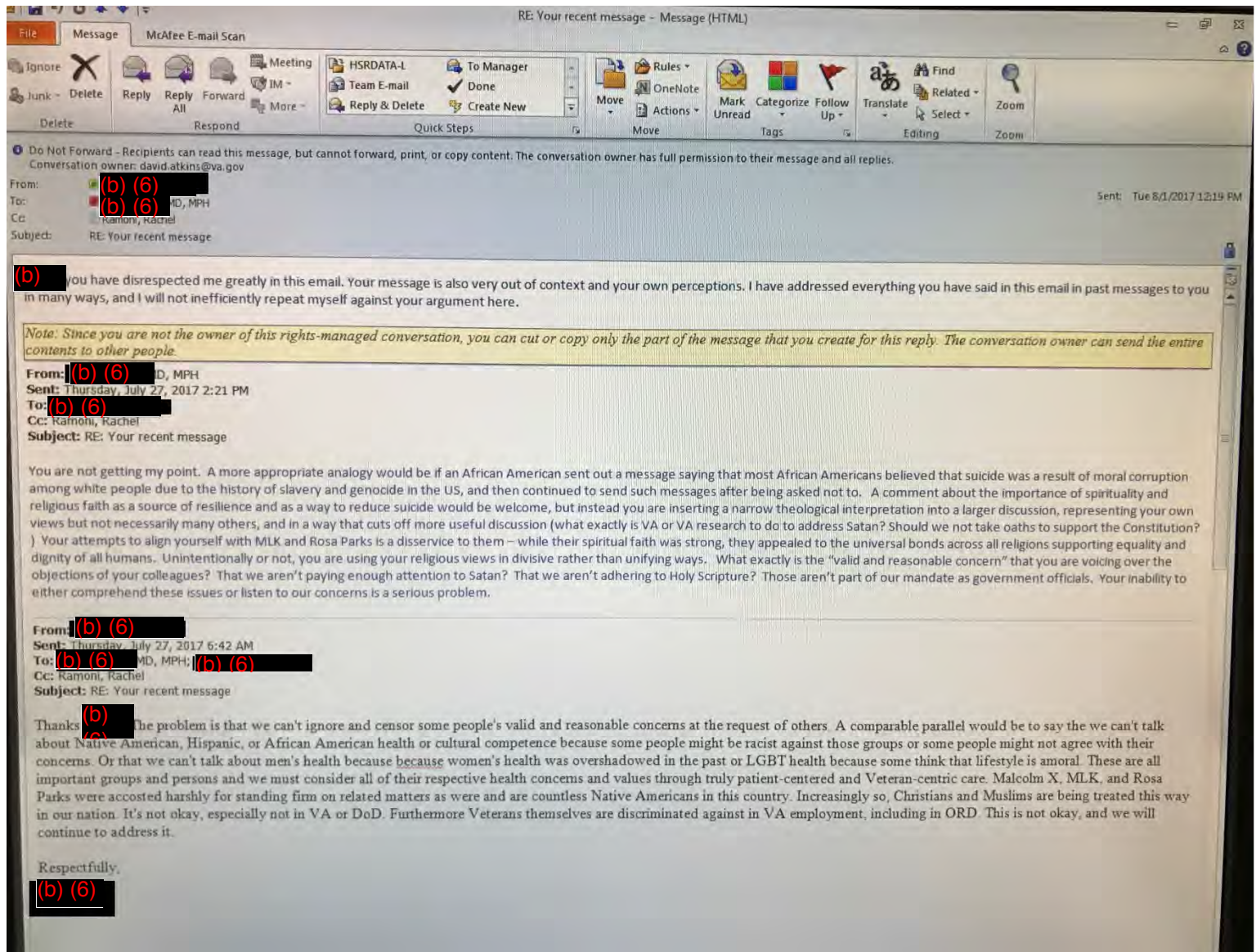


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/cn=recipients/cn=(b) (6), (b) (5)  
Filename: RE-Your recent message.pdf  
Last Modified: Mon Aug 28 12:38:56 CDT 2017

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See next pages for the rest of this original email message thread. (b) (6) reply above was sent as a reply only to (b) (6) on a thread that had included Rachel Ramoni before, and (b) (6) sent it in a way that cannot be forwarded, printed, or otherwise captured within the computer system, so the above is a photo taken of the computer screen it was displayed on. This is another example of how (b) (6) attempts to single out, bully, and disrespect (b) (6) behind figurative closed doors.

**From:** (b) (6)  
**To:** (b) (6) MD, MPH; (b) (6)  
**Cc:** [Ramoni, Rachel](#)  
**Subject:** RE: Your recent message  
**Date:** Thursday, July 27, 2017 6:42:22 AM

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Thanks David. The problem is that we can't ignore and censor some people's valid and reasonable concerns at the request of others. A comparable parallel would be to say the we can't talk about Native American, Hispanic, or African American health or cultural competence because some people might be racist against those groups or some people might not agree with their concerns. Or that we can't talk about men's health because because women's health was overshadowed in the past or LGBT health because some think that lifestyle is amoral. These are all important groups and persons and we must consider all of their respective health concerns and values through truly patient-centered and Veteran-centric care. Malcolm X, MLK, and Rosa Parks were accosted harshly for standing firm on related matters as were and are countless Native Americans in this country. Increasingly so, Christians and Muslims are being treated this way in our nation. It's not okay, especially not in VA or DoD. Furthermore Veterans themselves are discriminated against in VA employment, including in ORD. This is not okay, and we will continue to address it.

Respectfully,

(b) (6)

-----Original Message-----

**From:** (b) (6) MD, MPH  
**Sent:** Wednesday, July 26, 2017 05:10 PM Eastern Standard Time  
**To:** (b) (6)  
**Cc:** Ramoni, Rachel  
**Subject:** RE: Your recent message

(b) (6)

I don't think these comments are helping move the discussion forward and I do know these messages make some people uncomfortable, especially when you put out messages that purport to speak for the majority of Christian Veterans (or maybe you were only speaking of those with knowledge of scripture?). I am not sure what you mean when you say the discussion on these matters has changed. I have not changed in my request that you be more respectful of peoples differences and acknowledge that pushing your particular interpretation of religion is alienating your colleagues. There are many varieties of Christianity in this office, in the military and in VA and many non- Christians and non-believers as well, trying to work together for a common goal. These messages undermine that by imposing your own particular views on the process which excludes people who feel differently.

(b) (6)

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**From:** (b) (6)  
**Sent:** Wednesday, July 26, 2017 11:52 AM

**To:** (b) (6)  
**Cc:** (b) (6) MD, MPH; Ramoni, Rachel  
**Subject:** RE: Your recent message

Respectfully (b) (6) the discussion on these matters has changed. Please consult (b) (6) (b) (6)

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**From:** (b) (6)  
**Sent:** Wednesday, July 26, 2017 11:49 AM  
**To:** (b) (6)  
**Cc:** (b) (6) MD, MPH; (b) (6)  
**Subject:** Your recent message

(b) (6)

Your message below makes me uncomfortable – sending emails like these can be a form of proselytizing which I find inappropriate, discriminatory, and harassing. You have a right to your beliefs, but I find that subjecting people who don't share your beliefs to these types of emails interferes with the work environment, as not everyone may share your perspective and may not welcome or feel comfortable with these types of messages. We have communicated with you several times about the inappropriateness of these messages so please stop sending these immediately.

(b) (6)

---

**From:** (b) (6)  
**Sent:** Wednesday, July 26, 2017 9:46 AM  
**To:** (b) (6) <[@va.gov](mailto:(b) (6)@va.gov)>; VHA CO 10P9H Staff <[VHACO10P9HStaff@va.gov](mailto:VHACO10P9HStaff@va.gov)>  
**Subject:** RE: Is A New Military Oath Really The Best We Can Do To Fight Veteran Suicide?

There are a lot of very good points in this article. A “zero” suicide goal is further problematic as is an “oath” beyond the scientific evidence noted in the article. For example, for Christian Veterans (the majority) well knowledgeable on scripture (a lesser majority) they know that the only time there will be “zero” suicides on this earth are in the second half of Satan’s official 7 year reign (latter 3.5 years), or within Jesus’ Kingdom. Further, “oaths” trip a knowledgeable Christian’s radar as Jesus said, “... do not swear an oath at all... All you need to say is simply ‘Yes’ or ‘No’; anything beyond this comes from the evil one [Satan]” (as recorded in Matthew 5, [NIV]). Of course there is a lot more context to Jesus’ words.

Overall, though, the zero suicide goal and the proposed oath are a good start for this latest stage of discussion, with modification based on research and other guidance. With added knowledge and wisdom from behavioral medicine research, scripture, and other sources, there are a lot of clues for solid solutions and best practices.

---

**From:** (b) (6)  
**Sent:** Wednesday, July 26, 2017 8:47 AM

**To:** VHA CO 10P9H Staff

**Subject:** FW: Is A New Military Oath Really The Best We Can Do To Fight Veteran Suicide?

FYI-interesting article on the VA getting to zero initiative and related research:

[http://taskandpurpose.com/new-military-oath-really-best-can-fight-veteran-suicide/?utm\\_source=newsletter&utm\\_medium=email&utm\\_campaign=tp-today&utm\\_content=button](http://taskandpurpose.com/new-military-oath-really-best-can-fight-veteran-suicide/?utm_source=newsletter&utm_medium=email&utm_campaign=tp-today&utm_content=button)

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Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)  
/cn=recipients/cn=(b) (6), (b) (5) >  
Filename: RE: Follow-up (3).msg <extracted>  
Last Modified: Mon Aug 28 12:38:56 CDT 2017

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RE: Follow-up (3).msg <extracted> for Printed Item: 33 ( Attachment 3 of 7)  
**To:** Ramoni, Rachel[Rachel.Ramoni@va.gov]  
**From:** (b) (6)  
**Sent:** Mon 6/12/2017 7:27:46 PM  
**Subject:** RE: Follow-up

Hi Rachel,

I know you are doing the right thing with this from your experience, and I do very much appreciate it. However, based on the conversation we had on the phone and other factors, to an Army Veteran such as myself, this is a bit disrespectful, pedantic, and shows either a lack of trust or lack of experience with persons of honor (granted I and no one else are perfect). I take no offense as I understand you do not realize this.

As further background on myself, I also had an additional duty for a period in the Army as a suicide prevention officer.

You may be realizing quickly that I'm not here to play games. I know you are not either, and I'm sure it's a lot for you to have been pulled into this environment. I am part of the team that wants you to succeed, and I know how to do that from my lane.

I do appreciate your call and support. I'll be okay. The majority of our nation's 21 million Veterans will not as per statistics.

As I tell my family, if anything ever happens to me, you know where to find me, and you know how to get there.

Very respectfully,

(b) (6)

-----Original Message-----

**From:** Ramoni, Rachel  
**Sent:** Monday, June 12, 2017 02:51 PM Eastern Standard Time  
**To:** (b) (6)  
**Subject:** Follow-up

Dear (b) (6)  
Thank you for taking my call a few minutes ago. I was concerned about you and was glad to be able to speak with you.

I know that you said that you are not going to harm yourself. I did, though, want to remind you of the resources in VA.

The Veterans Crisis Line is confidential and is available by phone, online, or text. They can be reached **1-800-273-8255** and **Press 1**, at [chat online](#), or by sending a text message to **838255**. We also have our Employee Assistance Liaison, Aaron Jones. You can reach him at 202-461-5050 and 800-222-0364.

Yours,  
Rachel

Rachel B. Ramoni, DMD, ScD  
Chief Research and Development Officer  
Office of Research and Development  
Veteran's Health Administration  
**Research Saves Veterans' Lives**

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Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)  
/cn=recipients/cn=(b) (6), (b) (5) >  
Filename: RE: For Your Wellbeing--Honorable VA ORD Employees (4).msg <extracted>  
Last Modified: Mon Aug 28 12:38:56 CDT 2017

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**Examples of Their Wrongful Behavior:** See the enclosed bigoted and bullying email thread including strategies by (b) (6) and (b) (6) against me, with Rachel Cced on part of it, and her informed of all of it. In the email thread, (b) (6) first attempted to shut me down with the same method she used when they gave me a [wrongful] one week suspension without pay against a prior effort of mine to promote awareness via email of the Veterans we serve for their and our health. In similar fashion as before, David ultimately tries to shut me down in the email thread through bullying twists of my words, accusing me of being a "disrespectful" person. I have done a "disservice" by aligning myself with Martin Luther King Jr and Rosa Parks (as if I'm not good enough; exhibiting (b) (6))



RE: For Your Wellbeing--Honorable VA ORD Employees (4).msg <extracted> for Printed Item: 33 ( Attachment 4 of 4 )  
ignorance of who they are, what they stood for, how they stood, or why MLK was murdered). (b) (6) further disregards my mention of Malcolm X or LGBT. Given past context, (b) (6) omissions very likely are due to his bigotry in these areas as well. Where their behavior becomes bigoted and mine remains honorable, is they are very harshly trying to shut me and others down for sharing views and even facts that are contrary to their opinions or agendas. Their agendas at times are very corrupted and views quite narrow and biased. Not that anyone is perfect, but theirs is far from where it should be in their positions of power and authority for Veteran health research.

Rachel's email in relation to Federal policy on religion last week (Attached and dated August 17, 2017; the day after I was bullied by (b) (6) and (b) (6) back to safety at 810 Vermont) was also more attempts to appear a friend to all while deceptively shutting down important, candid conversations that she too does not agree with. Devout Jews, Christians, and Muslims especially know what I am talking about (Malcolm X and MLK where quite candid on this type of pseudo-friend behavior). There is more on record of Rachel at 810, both audio and email, and I am not going to share what I have of that to this broad audience. I assure you though, Rachel came to ORD pretending to be our friend, but she is using the information she obtained through that process wrongfully against you. Many of you are also aware of their wrongful attacks at me including lying to DHS in attempts to have them bully me.

Rachel (or her authorized representative) even lied to a DHS officer again this week about emails. This is egregious. DHS has more important life-saving homeland security work do to than respond to lies and games. The DHS Officer also told me candidly he reviewed the emails, only saw emails from me to Rachel, I included a representative from 810 on every email to I sent Rachel, and he also said that the emails he saw did not support her accusations. I was trying to help Rachel in sharing with her in those emails evidence of wrongful actions by her subordinate managers. This latest action from Rachel paired with her prior words and actions, on record, have made clear that she is in league with the corrupt managers and at this point trying to protect herself by being in league with them. I emailed her this information to protect her and other employees. This is the same reason I am emailing this to you, to help protect those among you that are honorable. For those who receive this message that are dishonorable—this is the last warning to you to resign before VA 810 Vermont leadership fire you.

What Rachel also doesn't seem to realize, is that (b) (6) and others have been in league against her, and they are still engaging in posturing behavior against her on different levels in attempts to cover themselves and their wrongdoing. I tried to protect her. She chose to trust the wrong side of the team, even after seeing and hearing their lies and bullying herself. She chose to listen to a greater volume of bad managers (e.g., (b) (6)) and those they promulgated against me, despite their lies and games, rather than listen to me, the disabled Veteran serving honorably. And whatever they think they may have on me, will only make them look worse and will not protect them from their own injustice. The worst thing about all of this is that it is occurring in a Veterans health research office.

**MLK and Me:** For more context on the aforementioned MLK dialogue and injustice, view this video of Martin Luther King Jr.'s response to white pastors criticizing him for going too far too fast: <https://www.youtube.com/watch?v=COKPs8VssX0&sns=em>. Please also read the sermon transcript, *When Peace Becomes Obnoxious*, where MLK states, "In a very profound passage which has been often misunderstood, Jesus utters this: He says, 'Think not that I am come to bring peace. I come not to bring peace but a sword.' Certainly, He is not saying that He comes not to bring peace in the higher sense. What He is saying is: 'I come not to bring this peace of escapism, this peace that fails to confront the real issues of life, the peace that makes for stagnant complacency,'" [http://kingencyclopedia.stanford.edu/encyclopedia/documentsentry/when\\_peace\\_becomes\\_obnoxious\\_sermon\\_delivered\\_on\\_18\\_march\\_1956.1.html](http://kingencyclopedia.stanford.edu/encyclopedia/documentsentry/when_peace_becomes_obnoxious_sermon_delivered_on_18_march_1956.1.html). And his quotes, "Injustice anywhere is a threat to justice everywhere," and "Our lives begin to end the day we become silent about the things that matter."

The VA ORD managers named in this email are comparable and worse than the white clergy trying to talk down MLK from standing firm. Their (bad ORD managers named) behavior is also comparable to such government officials as those who went along with the genocide in Nazi Germany that extended far beyond Jews; while my blue eyes would have protected me for a time then, if I'd have stepped an inch out of line and expressed my caretaking, protective of others nature—it would have given the Nazi's their justification to murder me too given certain other of my physical attributes such as my nose shape (likely from my Native American heritage), freckles (Irish), and physical injuries (even though from military service).

I am very much aligned with Martin Luther King Jr, in parallel with my people: Veterans and honorable VA employees; if you're not one of us as a VA employee—become one of us (i.e., start serving with honor and ICARE Values) or leave VA. This does not mean you have to work like crazy until your own health or family fails as the bad managers will drive you to do if you let them. This means being truly kind to others and reasonably doing your job, honorably in support of one another.

**Respectful Pragmatism:** My efforts are toward a healthier work environment with open-minded and inclusive solutions using healthy, respectful pragmatism. It would appear my positive and pragmatic means only seem to inflame them (e.g., Rachel, (b) (6))

(b) (6) ) to attack me and others. Of the most clear efforts of mine that inflame them is my mention of Jesus or Muhammed or the Bible or Quran or MLK or Malcolm X or persons of other faiths, ethnicities, or lifestyle preferences. Also of apparent, equal major concern to them is my mere mention of the forces working against our Veterans, VA employees, and others (e.g., Satan, corruption, lying, deceitfulness). This is very telling as to who or what they are serving or representing (it's certainly not Veterans or honorable VA employees that they are serving or representing).

**Accountability, Trust, Wellbeing:** We are bringing in a new era of accountability to VA and we will persevere in regaining the trust of Veterans and our employees. As a note, this is an independent message from me to promote trust and transparency by all parties. I share this for your wellness, that is, your honorable VA employee wellbeing. Whoever is not with us or at least neutral, is clearly against us. For persons with true and strong conviction of faith such as: Christians or Zoroastrians, we will actively resist them, for Jews and Muslims, we/they will fight them, for Hindus and Buddhists they will either remain neutral or assist against them in a variety of ways, for secular humanists or similar, they will assist as honorable employees against them ("them" in every case of this sentence means dishonorable people who are corrupt, using lies and games against honorable people and against our honorable VA mission; not people that make simple, reasonable mistakes, no one is perfect, but the corrupt people need to go).

**The Truly Dishonorable will be Removed:** Managers that would lie, gameplay, and try to bully a disabled Veteran out this bad, have no place in VA. They and managers like them further mismanage so poorly that they continually drive honorable VA employees out, and those that stay, they either bend them to their corrupt methods or drive them into the ground. We can better perform operations on 25% of our positions filled until we get more honorable support than we can with corrupt managers like them remaining in place. I assure you, they will be removed.

**Specifically, the Named Dishonorable Persons to be Removed:** Rachel Ramoni, (b) (6), and (b) (6) have until Monday morning to resign on their own recognizance, and not stay in US Federal Government Service in any capacity. They can start the process efficiently by a reply all to this email with an apology to you, ORD employees (indirectly by action for Veterans, VA, and taxpayers more generally) and then stating they are respectfully resigning their position effective immediately. They do not need to apologize to me; I'd actually prefer they didn't. They are already forgiven by me, but they will leave VA one way or another [administratively]. This is my final warning to the, which is actually showing them mercy. I warned them first by positive suggestion to just do what is right, then by more clear and direct terms, every step of the way over the past year—for them to clean up their behavior. If 810 Leadership have to remove them from VA service, it will affect their careers and lives far worse than their immediate resignation would over the next business day.

**In Closing:** Yes We Can [President Obama], Make America Great Again [President Trump]. Theirs' Nothing More Fun than Doing Something You Love With Somebody You Love [Secretary Bob], God Bless Our Veterans and Their Families [Secretary Shulkin]. This is our VA—Veterans and Honorable Employees.

In true humility, honor, and bipartisan service,

(b) (6)

Lifetime full member, DAV

Lifetime full member, VFW

US Army, Retired

Air Force Spouse to an Air Force Psychologist currently deployed to the Middle East

Dad of a 12 and 14 year old

Grandson of two WWII Veterans (1 US/ 1 Canadian)

Nephew and cousin of several Veterans

Brother of over 21-million living Veterans and all honorable VA employees

Brother of 9-million living VHA enrollees with me being a 50% service connected VHA enrolled patient (due to physical injuries in the military)

VA OAA Advanced Fellowship graduate

Member, Society of Behavioral Medicine

[This is a very small portion of my most relevant active affiliations or labels]

(b) (6), PhD, MPH

Health Science Officer

US Department of Veterans Affairs

810 Vermont Avenue NW

Washington, DC 20420

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**From:** Ramoni, Rachel  
**Sent:** Thursday, August 24, 2017 2:50 PM  
**To:** (b) (6) [REDACTED]; VHA CO 10P9 All Staff  
**Subject:** RE: AES response rate

Yes! A pizza party! With cake!

Rachel

Sent with Good ([www.good.com](http://www.good.com))

-----Original Message-----  
**From:** (b) (6) [REDACTED]  
**Sent:** Thursday, August 24, 2017 09:50 AM Eastern Standard Time  
**To:** VHA CO 10P9 All Staff  
**Subject:** AES response rate

All,

We are getting there. We've at least met our 60% goal. However, I know we can push this up over 80%. Please complete your AES survey today. We'll add a pizza party for everyone if we top 80%.



Program Office	Response Rate
Office of Deputy Under Secretary for Health for Policy and Services (10P)	100%+
Office of Strategic Integration (10A5)	100%+
ADUSH for Access	96.20%
Healthcare Leadership Talent Institute	94.10%
Office of Reporting Analytics Performance Improvement & Development (RAPID)	85.70%
Office of Patient Centered Care and Cultural Transformation (10NE)	83.90%
Office of National Center for Organization Development (10A2C)	82.10%
ADUSH for Integrity (10E1)	79.00%
Office of Interagency Health Affairs (10P5)	78.40%
Office of Academic Affiliations (10A2D)	77.80%
Office of Research Oversight (10R)	77.30%
Office of Research & Development (10P9)	73.80%
Office of Finance (10A3)	71.50%
ADUSH for Workforce Services (10A2)	63.60%
Office of Employee Education System (10A2B)	63.20%
Member Services (10NF)	62.40%
ADUSH for Informatics and Information Governance (10P2)	60.90%
Office of Deputy Under Secretary for Health for Organizational Excellence (10E)	59.00%
ADUSH for Policy & Planning (10P1)	58.50%
ADUSH for Patient Care Services (10P4)	56.80%
ADUSH for Quality, Safety, and Value (10E2)	56.60%
ADUSH for Administrative Operations (10NA)	55.80%
Office of Workforce Management and Consulting (10A2A)	55.20%
Office of Connected Health and Telehealth (10P8)	53.80%
Office of Readjustment Counseling (10P6S)	51.20%

(b) (6), *Ph.D.*

Director of Operations

Office of Research and Development (10P9)

Department of Veterans Affairs

810 Vermont Ave NW

Washington, DC 20420

(b) (6) [@va.gov](#)

202-443-(b) (6)

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Owner: (b) (6) . </o=va/ou=exchange administrative group (fydibohf23spdlt)  
/cn=recipients/cn=(b) (6), (b) (5) >  
Filename: image001.jpg <extracted>  
Last Modified: Mon Aug 28 12:38:56 CDT 2017

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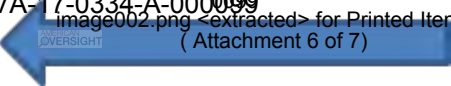
VA-17-0334-A-000097

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Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)  
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Last Modified: Mon Aug 28 12:38:56 CDT 2017

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17-A-17-0334-A-00000009  
image002.png <extracted> for Printed Item

AMERICAN  
OVERSIGHT

( Attachment 6 of 7 )

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Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)  
/cn=recipients/cn=(b) (6), (b) (5) >  
Filename: image003.png <extracted>  
Last Modified: Mon Aug 28 12:38:56 CDT 2017

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Program Office	Response Rate
Office of Deputy Under Secretary for Health for Policy and Services (10P)	100%+
Office of Strategic Integration (10A5)	100%+
ADUSH for Access	96.20%
Healthcare Leadership Talent Institute	94.10%
Office of Reporting Analytics Performance Improvement & Development (RAPID)	85.70%
Office of Patient Centered Care and Cultural Transformation (10NE)	83.90%
Office of National Center for Organization Development (10A2C)	82.10%
ADUSH for Integrity (10E1)	79.00%
Office of Interagency Health Affairs (10P5)	78.40%
Office of Academic Affiliations (10A2D)	77.80%
Office of Research Oversight (10R)	77.30%
Office of Research & Development (10P9)	73.80%
Office of Finance (10A3)	71.50%
ADUSH for Workforce Services (10A2)	63.60%
Office of Employee Education System (10A2B)	63.20%
Member Services (10NF)	62.40%
ADUSH for Informatics and Information Governance (10P2)	60.90%
Office of Deputy Under Secretary for Health for Organizational Excellence (10E)	59.00%
ADUSH for Policy & Planning (10P1)	58.50%
ADUSH for Patient Care Services (10P4)	56.80%
ADUSH for Quality, Safety, and Value (10E2)	56.60%
ADUSH for Administrative Operations (10NA)	55.80%
Office of Workforce Management and Consulting (10A2A)	55.20%
Office of Connected Health and Telehealth (10P8)	53.80%
Office of Readjustment Counseling (10RCS)	51.20%
Office of Nursing (10A1)	50.00%
Office of Procurement & Logistics (10NA2)	43.40%
ADUSH for Clinical Operations (10NC)	43.20%
DUSH for Community Care (10D)	42.20%
Veterans Canteen Service (10NA6)	39.50%
Office of Chief of Staff (10B)	38.20%
Office of Principal Deputy Under Secretary for Health (10A)	33.30%
Office of Specialty Care Services (10P11)	25.90%
Office of Deputy Under Secretary for Health for Operations & Management (10N)	13.90%
Office of the Under Secretary for Health (10)	Less than 5 Responses

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From: Americans for Limited Government  
<media@limitgov.org>  
To: Shulkin, David J., MD  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Cc:  
Bcc:  
Subject: [MARKETING] [EXTERNAL] How long before Democrat leaders denounce left-wing violence?  
Date: Thu Aug 24 2017 08:39:05 CDT  
Attachments:

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Why is the media giving Democrats a pass?

August 24, 2017

Permission to republish original op-eds and cartoons granted.

How long before Democrat leaders denounce left-wing violence against police in Phoenix, Boston, Portland and Washington, D.C.?

To prevent this violence from becoming legitimized, political leaders must stand up — now — and delegitimize it. Before it is too late. This can get much worse before the end.

GOP on the Hill are in a clown car playing chicken with a man driving a tank.

There have been recent reports the Trump administration is planning to use Deferred Action for Childhood Arrivals as a bargaining chip to get funding for the border wall in the upcoming Continuing Resolution. If so, this would break one campaign promise while attempting to keep another. The President must realize he cannot trust the other side to keep any promise and appreciate that he holds all the cards, despite the media spin.

Leave the Jefferson Memorial just the way it is

If you thought the good, national tidings emanating from America's solar eclipse would begin to bridge the racial divide arising from the recent fracas in Charlottesville, you'd be sadly mistaken. Worse, the open wounds are being poked and prodded by the very people who are responsible for reminding the public what unites – not divides – us as Americans.

Conservative Review: Kasich, GOP & Senate remain in health care cartels' pockets

In the ultimate case of the arsonists dressing up as firefighters, Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Lamar Alexander has invited two liberals to testify in September on "stabilizing" (i.e. bailing out) the insurance industry.

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How long before Democrat leaders denounce left-wing violence against police in Phoenix, Boston, Portland and Washington, D.C.?

By Robert Romano

Outside the speech given by President Donald Trump at Phoenix, Ariz. on Aug. 22, a riot broke out with violence directed at both Trump supporters and the police who were protecting the scene as police used gas to disperse the crowd.

The incident started after police said rocks and water bottles were thrown at them.

Although mild compared to the violence that erupted in Charlottesville, Va. where counter-protester Heather Heyer was killed, it is just the latest in what is becoming a scourge of political violence across the country — where speaking is not enough and protesters and counter-protesters are taking matters into their own hands.

Similar incidents have been occurring recently. In Boston, Mass. on Aug. 19, protesters threw rocks and bottles of urine at police at demonstrations.

In Portland, Oreg. on June 4, glass bottles and bricks were thrown at police by groups of anti-fascists ("Antifa") who showed up to disrupt a rally by supporters of President Donald Trump.

On Inauguration Day in Washington, D.C., rocks and bottles were thrown at police.

See a pattern?

Media and establishment figures are not helping matters.

The Washington Post in the wake of violence in Charlottesville published an oped by John Hopkins University associate professor N.B.D. Connolly that explicitly calls for political violence.

"Start throwing rocks," Connolly wrote.

Which, they already are. But then, Connolly knows that.

Elsewhere, the reality is that political violence is being normalized. Legitimized.

Comedian Kathy Griffin it will be remembered depicted the decapitation of Trump.

The New York City Public Theatre production of William Shakespeare's "Julius Caesar" depicted the assassination of Trump, turning what was a warning against political violence into a spectacle promoting it against the sitting President.

Democrat Missouri State Senator Maria Chappelle-Nadal called for Trump's assassination — and still has not resigned.

In June, a left-wing lunatic armed to the teeth shot U.S. Rep. Steve Scalise (R-La.) who is still recovering from his injuries.

None of this really needs to be centrally orchestrated or planned. There does not need to be a grand strategy. Revolutions rarely start in such pre-conceived fashion. Rather, they occur at opportune moments later when a government appears weak, and so groups coalesce and roll the dice.

Which is why leaders on the left need to start speaking up. Only a year ago, The Washington Post penned an editorial, "Violence is never the answer" in response to violence against Trump supporters in San Jose, Calif.

A year later, now the paper is publishing opeds advocating for that very violence.

In a statement after the riot in Phoenix, Americans for Limited Government President Rick Manning urged, "Hillary Clinton, Bernie Sanders and Elizabeth Warren should all denounce the attempt by the violent political wing of the Democrat Party known as Antifa, Black Lives Matter and Resist to shut down a speech by the President to his supporters. The effect of these Democrat Party surrogate groups is to attempt stifle and intimidate Americans from being able to attend an event featuring the duly elected President of the United States. Democrat Party leaders face a crossroads of whether to embrace violence as a legitimate means of political protest or to denounce it."

To prevent this violence from becoming legitimized, political leaders must stand up — now — and delegitimize it. Before it is too late. This can get much worse before the end.

Robert Romano is the Vice President of Public Policy of Americans for Limited Government.

---

Editorial: GOP on the Hill are in a clown car playing chicken with a man driving a tank.

By ALG Staff

There have been recent reports the Trump administration is planning to use Deferred Action for Childhood Arrivals (DACA) as a bargaining chip to get funding for the border wall in the upcoming Continuing Resolution (CR). If so, this would break one campaign promise while attempting to keep another. The President must realize he cannot trust the other side to keep any promise and appreciate that he holds all the cards, despite the media spin.

President Barack Obama issued many controversial edicts during his eight-year regime, but two of them drew the ire of Americans across the country. In 2012, Obama concocted the DACA program. He followed DACA with the Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) program in 2014.

DACA was a policy implemented to allow illegal immigrants brought to the U.S. as children to receive a renewable two-year safety net that gave them a work permit and deferred any deportation. Don't let the word "children" fool you, 64 percent of eligible applicants are legal adults, with 24 percent being 24 or older. It is estimated this program could affect up to 1.7 million illegal immigrants.

DAPA was a policy that targeted the illegal immigrant parents of children that were a U.S. citizen or permanent resident. It would do the same thing DACA did and grant a work permit and deferred deportation. This program had a larger impact than DACA. It was expected to affect 3.6 million people.

Make no mistake, both of these programs had one goal, amnesty. The Democrat party realizes it made a mistake by passing Obamacare instead of amnesty in 2010. In 2005, a Bear Stearns study put the number of illegal immigrants in the U.S. up near 20 million. Using two Pew Research studies putting the percentage of illegal immigrants from south of the border at 76 percent, and another study giving the Democrats 70 percent of that vote, the Democrats are fighting to add over 10.5 million new voters. If amnesty were to pass, Texas and Florida would be forever lost to the Republican party. This fight is literally the whole ball game.

On June 16, the Trump administration canceled the DAPA program after years of legal battles. Then on June 23, the Supreme Court affirmed a lower court ruling stating President Obama had overstepped his authority and ruled the program unconstitutional. Since the ruling, Homeland Security had been working out a way to take the program back to court until the cancellation.



Now, several states have threatened to sue the federal government if it does not end the DACA program.

This is where the President has the upper hand. Because the DAPA program was ruled unconstitutional and was founded on similar principles, the DACA program should be ruled the same, because it would be heard by the same court. DACA is off the table and does not matter.

The President can dare the Republicans in Congress to not fund a border wall, a border wall that he won the election on. He can do so because they want to fund an unconstitutional program. He can dare Republicans to shut down the government and break dozens of campaign promises. Republicans on the Hill are driving a clown car and playing chicken with a man driving a tank.

President Trump's base is unshakeable. For several months, the media has blasted the president with disproven story after disproven story. In the past two weeks reaching a new low and declaring the President racist, because he took the Martin Luther King, Jr. approach to violence. This did not shake his base. Even Democrat Super Pac MSNBC had to admit that President Trump's base was still with him earlier this week.

The same cannot be said for Congress. A new poll from Gallop shows that only 16 percent of Republicans approve of Congress. This is after Congress managed to accomplish nothing in 7 months. The numbers can only go down if more promises are broken with the CR.

The President can use the power of his Twitter account and challenge the Republicans that don't feel the need to keep America safe. Nothing scares a Member of Congress more than a primary challenger. The President has already done so with Sen. Jeff Flake (R-Ariz.) and a new poll shows his challenger Kelli Ward leading him by 14 points.

The President has the bully pulpit and his world-famous media obsessed Twitter account which allows him to put pressure where it belongs, on Members of Congress. The President needs to be willing to travel to the districts and states of troublesome GOPers, and threaten to support a primary challenger. Primary season is coming up, and the last thing any member wants to see is the leader of their party shaking hands with their challenger.

---

Leave the Jefferson Memorial just the way it is

By Peter Hong

If you thought the good, national tidings emanating from America's solar eclipse would begin to bridge the racial divide arising from the recent fracas in Charlottesville, you'd be sadly mistaken. Worse, the open wounds are being poked and prodded by the very people who are responsible for reminding the public what unites – not divides – us as Americans.

The Washington Examiner reports that the Jefferson Memorial will be "updated" to reflect the fact that the author of the Declaration of Independence and the third President of the United States was a slaveholder. The announcement was made by Catherine Perkins from the Trust for the National Mall ("Trust"), the non-profit partner of the National Park Service to preserve and restore the National Mall and Memorial Parks.

According to Perkins, the Jefferson Memorial "update" will mark the first in a series of historical revisions to landmarks under the Trust's stewardship. Projects supported by the Trust include the Washington Monument, the Lincoln Memorial, and the FDR Memorial. According to Ms. Perkins:

Hate and violence have no place in our public discourse. In the coming weeks and months, the physical symbols of American history and democracy will be scrutinized and challenged. We understand this debate is likely to extend to the National Mall, including many projects supported by the Trust. When that happens, we will work with our partners to ensure the National Mall continues to be a vibrant and relevant place where Americans can learn about our history and imagine our future, together.

In other words, Ms. Perkins' Trust is unilaterally surrendering to the likes of Al Sharpton even before he rounds up Black Lives Matter and some Antifa thugs to tear down the Jefferson Memorial altogether. Instead of schooling the barbarians at the gate, better to placate them with a slice of our national integrity.

For sports fans and history buffs, this travesty is analogous to enshrining Barry Bonds to baseball's Hall of Fame, while shaming him with an asterisk as a steroid user. In Bonds' case, the asterisk denotes something directly related to his accomplishments; the attacks on Jefferson are purely personal. And while Bonds was a great player, Jefferson is literally on the Mount Rushmore of American history.

As a private citizen, Jefferson did own slaves, personally profited from the institution of slavery and kept Sally Hemmings as a mistress. These facts are well-known and undisputed.

As a public figure, Thomas Jefferson opposed the institution of slavery. On the northeast portico of the Jefferson Memorial itself are these words penned by Jefferson himself:

God who gave us life gave us liberty. Can the liberties of a nation be secure when we have removed a conviction that these liberties are the gift of God? Indeed I tremble for my country when I reflect that God is just, that his justice cannot sleep forever. Commerce between master and slave is despotism. Nothing is more certainly written in the book of fate than these people are to be free.

If you want to learn more about Thomas Jefferson the man, you need only drive two hours west of the Jefferson Memorial to his home in Monticello. There, you can learn everything you want about Jefferson, the thinker; Jefferson, the architect; Jefferson, the inventor; Jefferson, the naturalist.

And, yes, even Jefferson, the slave owner. In fact, you can embark on one of the daily "Slavery at Monticello" tours and download the free "Slavery at Monticello" app, if you so choose.

National memorials were not meant to expose the personal frailties of our leaders, but to celebrate the invaluable contributions they made to advance the American idea.

If we were to mark our collective remembrances of American heroes by their personal failings, we would denigrate George Washington as a slave owner, brand Abraham Lincoln a depressive, and chastise JFK, FDR, and MLK as adulterers. In fact, there is a high likelihood that Washington will be the next target if Ms. Perkins and the "Trust" are not stopped now.

One prominent feature that has historically distinguished Americans from the rest of the world's inhabitants is our shared spirit of optimism and hopefulness. Sometimes right, sometimes wrong, but never in doubt, we Americans may pause for reflection, but do not fall for introspection – and that's a good thing.

Apparently, the Trust for the National Mall doesn't get it. Rick Manning, President of Americans for Limited Government, says the Trust's actions are grounds for dismissal:

"Interior Secretary Ryan Zinke needs to set the record straight that a private non-profit group known as



the Trust for the National Mall does not control memorial or museum content on the National Mall. While the money this non-profit, tax-exempt group raises to restore the Mall is appreciated, it does not give them the authority to change the Jefferson Memorial or any other statues in the name of political correctness. If the 'Trust' insists on changes, the Department of Interior should discontinue all ties with the group. The Jefferson Memorial and Washington Monument are testimonies to honor the ideals exemplified in the founding by Thomas Jefferson and George Washington, not to tear them down. They should be left just the way they are."

Sources close to Interior Secretary Zinke express confidence that Zinke will not surrender control over the monuments to an associated non-profit, like the Trust.

Winston Churchill said, "History is written by the victors." There is now a dangerous, concerted effort to have it rewritten by the appeasers. Mr. Jefferson would not be pleased.

Peter Hong is a contributing reporter at Americans for Limited Government.

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ALG Editor's Note: In the following piece from Conservative review, Daniel Horowitz describes how the GOP is working with democrats to save Obamacare:

Conservative Review: Kasich, GOP & Senate remain in health care cartels' pockets

By Daniel Horowitz

In the ultimate case of the arsonists dressing up as firefighters, Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Lamar Alexander has invited two liberals to testify in September on "stabilizing" (i.e. bailing out) the insurance industry.

Who are the two liberals? Governors John Hickenlooper and ... John Kasich! Thus, we will have a hearing on how to bail out the industry that 1) destroyed health care prior to Obamacare, and 2) exacerbated it by supporting Obamacare and blocking repeal.

Then two governors owned by the insurance and hospital cartel will testify on their behalf. THAT is what is called "bipartisanship" in Washington. And THIS is what is meant by GOP control of the Senate.

Here is the focus of the Sept. 7 hearing, according to CQ (subscription required):

Ohio Gov. John Kasich, a Republican, and Colorado Gov. John Hickenlooper, a Democrat, told Colorado Matters in a Monday interview they are working on a joint health care plan focused on stabilization. Their plan could be ready as soon as next week and they hope it will win the support of other governors, Kasich said. [...]

Both have called for Congress to allocate funding for the law's cost-sharing reduction payments, which would alleviate uncertainty for insurers. Insurers have made it clear that they will increase their premium rates in the individual market if the administration does not continue making the CSR payments.

This is an utter disgrace. Nobody embodies the government-insurance industry complex more than John Kasich.

In Ohio, he placed personal connections in insurance and hospital lobbies above the interests of the consumer at every turn. He has vetoed every effort by the Republican-controlled legislature to rein in

Obamacare, reduce spending, improve consumer choice, and prevent more taxpayer dollars from lining the pockets of the cartel.

The Ohio governor should be the poster child of what not to do with health care.

Get the full story here.

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10332 Main Street #326  
Fairfax, VA 22030

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From: (b) (6). </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5) >  
To: Shulkin, David J., MD  
</o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)  
Cc: Lee, Jennifer S. (VACO)  
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Bcc:  
Subject: FYSA- FW: Lu- FW: For Your Wellbeing--Honorable VA ORD Employees  
Date: Fri Aug 25 2017 15:37:10 CDT  
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image002.png  
image003.png  
Notes from Rachel (the CRADO) (5).msg  
image001  
image002.png  
image003.jpg  
RE-Your recent message.pdf

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FYSA

From: (b) (6)  
Sent: Friday, August 25, 2017 4:36 PM  
To: Beck, Lucille B.  
Subject: Lu- FW: For Your Wellbeing--Honorable VA ORD Employees

Hi Lu,

Please see the enclosed. If you are unable to move toward your next step by Monday morning and immediately suspend, then remove Rachel Ramoni (b) (6) from VA service (provided they have not resigned first), I will move toward my next administrative step higher in the chain of command to ensure their swift removal from VA on Monday.

No worries, all administrative. For your and everyone's sanity at 810 that may still be trusting the promulgation by the (b) (6) et al group, I will not be in Washington DC this weekend or on Monday. You can reach me on my work mobile Monday (listed below).

I am spending the weekend with my children, they are 12 and 14 years old and my wife is deployed to the Middle East, so I'm essentially a single parent this weekend. I do not need any VA ORD/HSRD drama this weekend, but I needed to get the enclosed message out to ORD as I have been hearing from other employees as to some things continuing to go on there.

Again, no worries. Have a good weekend.

In honor and service,

(b)  
(6)

[REDACTED], PhD, MPH

Health Science Officer

Health Services Research & Development

US Department of Veterans Affairs

810 Vermont Avenue NW (10P9H)

Washington, DC 20420

Office: (202) 443-(b)  
(6)

Work mobile: (202) 870-(b)  
(6)

Email: (b) (6) @va.gov

From: (b) (6)  
Sent: Friday, August 25, 2017 4:23 PM  
To: VHA CO 10P9 All Staff  
Subject: For Your Wellbeing--Honorable VA ORD Employees

Dear Honorable ORD Employees,

Do not trust Rachel Ramoni, (b) (6) or (b) (6) at all, nor (b) (6), nor (b) (6). They are corrupt, lying wolves in sheep's clothing. They will be removed administratively from VA very soon if they do not resign first. They would be wise to resign first rather than be fired. I

also send this message with much humility, despite appearances. And yes the length is warranted to get this message out. If you think it's too long, then consider the letters or scripture books in the Torah, New Testament, Talmud, or Surahs in the Quran and then consider the background of the author of this message and all of the injustice in ORD alone.

I recommend if you are receiving this on Friday afternoon to just print it and read in on your ride home, or if driving, when you get home (don't forget to print the attached emails/PDF). Have a nice weekend, no worries.

Candid: If you think my candid words in this email or otherwise to promote transparency and trust in our organization are too much or too harsh, you will see in this message a glimpse of their harsh words and actions against me as a disabled Veteran in VA, against others, and against our VA mission and Nation's values, by these perpetrators. I was likely the decoy, and they failed at every step. Furthermore, our Veterans and many other Americans, residents, and visitors are dying wrongfully because of them and people like them. This is not retaliation—We simply cannot afford corrupt managers like this in VA.

Very Candid: The top singular and clear issue of concern in VA is the average 20 suicides per day among our Veterans. I had a bad dream a few weeks ago that one of our VA ORD colleague's spouses died and our ORD colleague then committed suicide in our office; I will not say who it was. I know at least one of my VA colleagues in ORD is struggling only 1 major adverse life event away from ending their own life and very likely there are more. This is in part because of corrupt managers. I assure all of you, help is on the way, and I am here for you as we all support one another and our Veterans. If you are one of the corrupt managers, you too have an honorable way out by turning from your corrupt ways and doing the right thing, getting help, and treating others better moving forward. The gravity of this situation is why I'm emailing you directly rather than waiting on 810 Vermont leadership.

On Record: There is also plenty of recorded audio that 810 Vermont has; we have heard them (the corrupt) and we hear you (the honorable). Of course no one is perfect, but they have very much crossed the line from their positions of power and authority that they use to abuse others. If you find yourself wanting to help them in any way other than helping them find their way out of VA, you are either on their corrupt side and will likely be leaving too, or you are greatly deceived with an opportunity out to do the right thing and serve honorably away from them. No worries, this is 100% administrative with no threat to anyone's physical safety unless one of the perpetrators named in this email or their wrongful consorts chooses to do so. They have already been attacking your psychological safety and wellbeing immensely.

Examples of Their Wrongful Behavior: See the enclosed bigoted and bullying email thread including strategies by (b) (6) and (b) (6) against me, with Rachel Cced on part of it, and her informed of all of it. In the email thread, (b) (6) first attempted to shut me down with the same method she used when they gave me a [wrongful] one week suspension without pay against a prior effort of mine to promote awareness via email of the Veterans we serve for their and our health. In similar fashion as before, David ultimately tries to shut me down in the email thread through bullying twists of my words, accosting me 1-1, even saying I have done a "disservice" by aligning myself with Martin Luther King Jr and Rosa Parks (as if I'm not good enough; exhibiting (b) (6) ignorance of who they are, what they stood for, how they stood, or why MLK was murdered). (b) (6) further disregards my mention of Malcolm X or LGBT. Given past context, (b) (6) omissions very likely are due to his bigotry in

these areas as well. Where their behavior becomes bigoted and mine remains honorable, is they are very harshly trying to shut me and others down for sharing views and even facts that are contrary to their opinions or agendas. Their agendas at times are very corrupted and views quite narrow and biased. Not that anyone is perfect, but theirs is far from where it should be in their positions of power and authority for Veteran health research.

Rachel's email in relation to Federal policy on religion last week (Attached and dated August 17, 2017; the day after I was bullied by (b) (6) and (b) (6) back to safety at 810 Vermont) was also more attempts to appear a friend to all while deceptively shutting down important, candid conversations that she too does not agree with. Devout Jews, Christians, and Muslims especially know what I am talking about (Malcolm X and MLK where quite candid on this type of pseudo-friend behavior). There is more on record of Rachel at 810, both audio and email, and I am not going to share what I have of that to this broad audience. I assure you though, Rachel came to ORD pretending to be our friend, but she is using the information she obtained through that process wrongfully against you. Many of you are also aware of their wrongful attacks at me including lying to DHS in attempts to have them bully me.

Rachel (or her authorized representative) even lied to a DHS officer again this week about emails. This is egregious. DHS has more important life-saving homeland security work to do than respond to lies and games. The DHS Officer also told me candidly he reviewed the emails, only saw emails from me to Rachel, I included a representative from 810 on every email to I sent Rachel, and he also said that the emails he saw did not support her accusations. I was trying to help Rachel in sharing with her in those emails evidence of wrongful actions by her subordinate managers. This latest action from Rachel paired with her prior words and actions, on record, have made clear that she is in league with the corrupt managers and at this point trying to protect herself by being in league with them. I emailed her this information to protect her and other employees. This is the same reason I am emailing this to you, to help protect those among you that are honorable. For those who receive this message that are dishonorable—this is the last warning to you to resign before VA 810 Vermont leadership fire you.

What Rachel also doesn't seem to realize, is that (b) (6) and others have been in league against her, and they are still engaging in posturing behavior against her on different levels in attempts to cover themselves and their wrongdoing. I tried to protect her. She chose to trust the wrong side of the team, even after seeing and hearing their lies and bullying herself. She chose to listen to a greater volume of bad managers (e.g., (b) (6)) and those they promulgated against me, despite their lies and games, rather than listen to me, the disabled Veteran serving honorably. And whatever they think they may have on me, will only make them look worse and will not protect them from their own injustice. The worst thing about all of this is that it is occurring in a Veterans health research office.

MLK and Me: For more context on the aforementioned MLK dialogue and injustice, view this video of Martin Luther King Jr.'s response to white pastors criticizing him for going too far too fast: <https://www.youtube.com/watch?v=C0KPs8VssX0&sns=em>. Please also read the sermon transcript, When Peace Becomes Obnoxious, where MLK states, "In a very profound passage which has been often misunderstood, Jesus utters this: He says, 'Think not that I am come to bring peace. I come not to bring peace but a sword.' Certainly, He is not saying that He comes not to bring peace in the higher sense. What He is saying is: 'I come not to bring this peace of escapism, this peace that fails to confront the real issues of life, the peace that makes for stagnant complacency,'" [http://kingencyclopedia.stanford.edu/encyclopedia/documententry/when\\_peace\\_becomes\\_obnoxious\\_sermon\\_delivered\\_on\\_18\\_march\\_1956.1.html](http://kingencyclopedia.stanford.edu/encyclopedia/documententry/when_peace_becomes_obnoxious_sermon_delivered_on_18_march_1956.1.html). And his quotes, "Injustice anywhere is a threat to justice everywhere," and "Our lives begin to end the day we become silent about the things that matter."

The VA ORD managers named in this email are comparable and worse than the white clergy trying to talk down MLK from standing firm. Their (bad ORD managers named) behavior is also comparable to such government officials as those who went along with the genocide in Nazi Germany that extended far beyond Jews; while my blue eyes would have protected me for a time then, if I'd have stepped an inch out of line and expressed my caretaking, protective of others nature—it would have given the Nazi's their justification to murder me too given certain other of my physical attributes such as my nose shape (likely from my Native American heritage), freckles (Irish), and physical injuries (even though from military service).

I am very much aligned with Martin Luther King Jr, in parallel with my people: Veterans and honorable VA employees; if you're not one of us as a VA employee—become one of us (i.e., start serving with honor and ICARE Values) or leave VA. This does not mean you have to work like crazy until your own health or family fails as the bad managers will drive you to do if you let them. This means being truly kind to others and reasonably doing your job, honorably in support of one another.

Respectful Pragmatism: My efforts are toward a healthier work environment with open-minded and inclusive solutions using healthy, respectful pragmatism. It would appear my positive and pragmatic means only seem to inflame them (e.g., Rachel, (b) (6)) to attack me and others. Of the most clear efforts of mine that inflame them is my mention of Jesus or Muhammed or the Bible or Quran or MLK or Malcolm X or persons of other faiths, ethnicities, or lifestyle preferences. Also of apparent, equal major concern to them is my mere mention of the forces working against our Veterans, VA employees, and others (e.g., Satan, corruption, lying, deceitfulness). This is very telling as to who or what they are serving or representing (it's certainly not Veterans or honorable VA employees that they are serving or representing).

Accountability, Trust, Wellbeing: We are bringing in a new era of accountability to VA and we will persevere in regaining the trust of Veterans and our employees. As a note, this is an independent message from me to promote trust and transparency by all parties. I share this for your wellness, that is, your honorable VA employee wellbeing. Whoever is not with us or at least neutral, is clearly against us. For persons with true and strong conviction of faith such as: Christians or Zoroastrians, we will actively resist them, for Jews and Muslims, we/they will fight them, for Hindus and Buddhists they will either remain neutral or assist against them in a variety of ways, for secular humanists or similar, they will assist as honorable employees against them ("them" in every case of this sentence means dishonorable people who are corrupt, using lies and games against honorable people and against our honorable VA mission; not people that make simple, reasonable mistakes, no one is perfect, but the corrupt people need to go).

The Truly Dishonorable will be Removed: Managers that would lie, gameplay, and try to bully a disabled Veteran out this bad, have no place in VA. They and managers like them further mismanage so poorly that they continually drive honorable VA employees out, and those that stay, they either bend them to their corrupt methods or drive them into the ground. We can better perform operations on 25% of our positions filled until we get more honorable support than we can with corrupt managers like them remaining in place. I assure you, they will be removed.

Specifically, the Named Dishonorable Persons to be Removed: Rachel Ramoni, (b) (6) [REDACTED] and (b) (6) [REDACTED] have until Monday morning to resign on their own recognizance, and not stay in US Federal Government Service in any capacity. They can start the process efficiently by a reply all to this email with an apology to you, ORD employees (indirectly by action for Veterans, VA, and taxpayers more generally) and then stating they are respectfully resigning their position effective immediately. They do not need to apologize to me; I'd actually prefer they didn't. They are already forgiven by me, but they will leave VA one way or another [administratively]. This is my final warning to the, which is actually showing them mercy. I warned them first by positive suggestion to just do what is right, then by more clear and direct terms, every step of the way over the past year—for them to clean up their behavior. If 810 Leadership have to remove them from VA service, it will affect their careers and lives far worse than their immediate resignation would over the next business day.

In Closing: Yes We Can [President Obama], Make America Great Again [President Trump]. Theirs' Nothing More Fun than Doing Something You Love With Somebody You Love [Secretary Bob], God Bless Our Veterans and Their Families [Secretary Shulkin]. This is our VA—Veterans and Honorable Employees.

In true humility, honor, and bipartisan service,

(b) (6)

Lifetime full member, DAV

Lifetime full member, VFW

US Army, Retired

Air Force Spouse to an Air Force Psychologist currently deployed to the Middle East

Dad of a 12 and 14 year old

Grandson of two WWII Veterans (1 US/ 1 Canadian)

Nephew and cousin of several Veterans

Brother of over 21-million living Veterans and all honorable VA employees

Brother of 9-million living VHA enrollees with me being a 50% service connected VHA enrolled patient (due to physical injuries in the military)

VA OAA Advanced Fellowship graduate

Member, Society of Behavioral Medicine

[This is a very small portion of my most relevant active affiliations or labels]



(b) (6), PhD, MPH

Health Science Officer

US Department of Veterans Affairs

810 Vermont Avenue NW

Washington, DC 20420

Office: (202) 443-(b) (6)

Work mobile: (202) 870-(b) (6)

Email: (b) (6)@va.gov

From: Ramoni, Rachel

Sent: Thursday, August 24, 2017 2:50 PM

To: (b) (6); VHA CO 10P9 All Staff

Subject: RE: AES response rate

Yes! A pizza party! With cake!

Rachel

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6)

Sent: Thursday, August 24, 2017 09:50 AM Eastern Standard Time

To: VHA CO 10P9 All Staff

Subject: AES response rate

All,

We are getting there. We've at least met our 60% goal. However, I know we can push this up over 80%. Please complete your AES survey today. We'll add a pizza party for everyone if we top 80%.

(b) (6), Ph.D.

Director of Operations

Office of Research and Development (10P9)

Department of Veterans Affairs

810 Vermont Ave NW

Washington, DC 20420

(b) (6)@va.gov

202-443-(b) (6)

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Owner: (b) (6) P. </o=va/ou=exchange administrative group (fydibohf23spdlt)  
/cn=recipients/cn=(b) (6), (b) (5)  
Filename: FW: AES response rate (1).msg <extracted>  
Last Modified: Fri Aug 25 15:37:10 CDT 2017

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FW: AES response rate (1).msg <extracted> for Printed Item: 42 ( Attachment 1 of 12)  
**To:** VHA CO 10P9H Staff [VHACO10P9HStaff@va.gov]  
**From:** (b) (6) MD, MPH  
**Sent:** Fri 8/25/2017 1:01:22 PM  
**Subject:** FW: AES response rate

If you haven't completed AES please take some time to do so before Monday. We take these results seriously and want to see if we have new areas to address. Also, need to get to pizza party goal.

(b) (6) MD, MPH

-----Original Message-----

**From:** (b) (6)  
**Sent:** Thursday, August 24, 2017 09:50 AM Eastern Standard Time  
**To:** VHA CO 10P9 All Staff  
**Subject:** AES response rate

All,

We are getting there. We've at least met our 60% goal. However, I know we can push this up over 80%. Please complete your AES survey today. We'll add a pizza party for everyone if we top 80%.



Program Office	Response Rate
Office of Deputy Under Secretary for Health for Policy and Services (10P)	100%+
Office of Strategic Integration (10A5)	100%+
ADUSH for Access	96.20%
Healthcare Leadership Talent Institute	94.10%
Office of Reporting Analytics Performance Improvement & Development (RAPID)	85.70%
Office of Patient Centered Care and Cultural Transformation (10NE)	83.90%
Office of National Center for Organization Development (10A2C)	82.10%
ADUSH for Integrity (10E1)	79.00%
Office of Interagency Health Affairs (10P5)	78.40%
Office of Academic Affiliations (10A2D)	77.80%
Office of Research Oversight (10R)	77.30%
Office of Research & Development (10P9)	73.80%
Office of Finance (10A3)	71.50%
ADUSH for Workforce Services (10A2)	63.60%
Office of Employee Education System (10A2B)	63.20%
Member Services (10NF)	62.40%
ADUSH for Informatics and Information Governance (10P2)	60.90%
Office of Deputy Under Secretary for Health for Organizational Excellence (10E)	59.00%
ADUSH for Policy & Planning (10P1)	58.50%
ADUSH for Patient Care Services (10P4)	56.80%
ADUSH for Quality, Safety, and Value (10E2)	56.60%
ADUSH for Administrative Operations (10NA)	55.80%
Office of Workforce Management and Consulting (10A2A)	55.20%
Office of Connected Health and Telehealth (10P8)	53.80%
Office of Readjustment Counseling (10P6S)	51.20%

(b) (6), *Ph.D.*

Director of Operations

Office of Research and Development (10P9)

Department of Veterans Affairs

810 Vermont Ave NW

Washington, DC 20420

(b) (6) [@va.gov](#)

202-443-(b) (6)

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VA-17-0334-A-0009122



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17-A-17-0334-A-00004124  
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AMERICAN  
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( Attachment 3 of 12 )

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Program Office	Response Rate
Office of Deputy Under Secretary for Health for Policy and Services (10P)	100%+
Office of Strategic Integration (10A5)	100%+
ADUSH for Access	96.20%
Healthcare Leadership Talent Institute	94.10%
Office of Reporting Analytics Performance Improvement & Development (RAPID)	85.70%
Office of Patient Centered Care and Cultural Transformation (10NE)	83.90%
Office of National Center for Organization Development (10A2C)	82.10%
ADUSH for Integrity (10E1)	79.00%
Office of Interagency Health Affairs (10P5)	78.40%
Office of Academic Affiliations (10A2D)	77.80%
Office of Research Oversight (10R)	77.30%
Office of Research & Development (10P9)	73.80%
Office of Finance (10A3)	71.50%
ADUSH for Workforce Services (10A2)	63.60%
Office of Employee Education System (10A2B)	63.20%
Member Services (10NF)	62.40%
ADUSH for Informatics and Information Governance (10P2)	60.90%
Office of Deputy Under Secretary for Health for Organizational Excellence (10E)	59.00%
ADUSH for Policy & Planning (10P1)	58.50%
ADUSH for Patient Care Services (10P4)	56.80%
ADUSH for Quality, Safety, and Value (10E2)	56.60%
ADUSH for Administrative Operations (10NA)	55.80%
Office of Workforce Management and Consulting (10A2A)	55.20%
Office of Connected Health and Telehealth (10P8)	53.80%
Office of Readjustment Counseling (10RCS)	51.20%
Office of Nursing (10A1)	50.00%
Office of Procurement & Logistics (10NA2)	43.40%
ADUSH for Clinical Operations (10NC)	43.20%
DUSH for Community Care (10D)	42.20%
Veterans Canteen Service (10NA6)	39.50%
Office of Chief of Staff (10B)	38.20%
Office of Principal Deputy Under Secretary for Health (10A)	33.30%
Office of Specialty Care Services (10P11)	25.90%
Office of Deputy Under Secretary for Health for Operations & Management (10N)	13.90%
Office of the Under Secretary for Health (10)	Less than 5 Responses

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VA-17-0334-A-0009128



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OVERSIGHT

Attachment 6 of 12)

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Program Office	Response Rate
Office of Deputy Under Secretary for Health for Policy and Services (10P)	100%+
Office of Strategic Integration (10A5)	100%+
ADUSH for Access	96.20%
Healthcare Leadership Talent Institute	94.10%
Office of Reporting Analytics Performance Improvement & Development (RAPID)	85.70%
Office of Patient Centered Care and Cultural Transformation (10NE)	83.90%
Office of National Center for Organization Development (10A2C)	82.10%
ADUSH for Integrity (10E1)	79.00%
Office of Interagency Health Affairs (10P5)	78.40%
Office of Academic Affiliations (10A2D)	77.80%
Office of Research Oversight (10R)	77.30%
Office of Research & Development (10P9)	73.80%
Office of Finance (10A3)	71.50%
ADUSH for Workforce Services (10A2)	63.60%
Office of Employee Education System (10A2B)	63.20%
Member Services (10NF)	62.40%
ADUSH for Informatics and Information Governance (10P2)	60.90%
Office of Deputy Under Secretary for Health for Organizational Excellence (10E)	59.00%
ADUSH for Policy & Planning (10P1)	58.50%
ADUSH for Patient Care Services (10P4)	56.80%
ADUSH for Quality, Safety, and Value (10E2)	56.60%
ADUSH for Administrative Operations (10NA)	55.80%
Office of Workforce Management and Consulting (10A2A)	55.20%
Office of Connected Health and Telehealth (10P8)	53.80%
Office of Readjustment Counseling (10RCS)	51.20%
Office of Nursing (10A1)	50.00%
Office of Procurement & Logistics (10NA2)	43.40%
ADUSH for Clinical Operations (10NC)	43.20%
DUSH for Community Care (10D)	42.20%
Veterans Canteen Service (10NA6)	39.50%
Office of Chief of Staff (10B)	38.20%
Office of Principal Deputy Under Secretary for Health (10A)	33.30%
Office of Specialty Care Services (10P11)	25.90%
Office of Deputy Under Secretary for Health for Operations & Management (10N)	13.90%
Office of the Under Secretary for Health (10)	Less than 5 Responses

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Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)  
/cn=recipients/cn=(b) (6), (b) (5) >  
Filename: Notes from Rachel (the CRADO) (5).msg <extracted>  
Last Modified: Fri Aug 25 15:37:10 CDT 2017

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To: Notes from Rachel (the CRADO) (5) msg extracted for Printed Item: 42 ( Attachment 8 of 12)  
VHA CO 10P9 All Staff[VHACO10P9AllStaff@va.gov]  
From: Ramoni, Rachel  
Sent: Thur 8/17/2017 7:48:07 PM  
Subject: Notes from Rachel (the CRADO)

## *Notes from Rachel*



Hello! We have a big office here, and I'm trying this as a way to better share what I'm hearing in central office, what I'm thinking about, and to answer questions that come to me. The photo above is from my recent trip to Scotland. If you haven't been there, it is a beautiful place, though their definition of summer is very different from our summer here in DC.

**Modernization & Hiring freeze:** Modernization continues to be a major topic at 810 Vermont Ave. It is not clear what the final organizational chart will look like: what is clear is that it will look very different from our current chart.

As all of you must know, we are still under a hiring freeze here at central office, and there doesn't seem to be much appetite for thawing the freeze until after modernization. After *a lot* of hard work, (b) (6) got permission to submit some positions to be considered for exemptions, so I finally have some reason to be optimistic that we'll get some relief.

I know that you are working hard to keep our operations going in spite of the freeze. I so much appreciate that. I must also acknowledge that, in this context, we have to be very careful about what initiatives we take on. I'll be speaking to the Directors to find out where we can focus our efforts and what we have to pause until we get more team members here.

**Religious Expression:** I've been learning a lot about Federal policies. One of our strengths here at ORD is our diversity, so I was drawn to "Guidelines on religious exercise and religious expression in the federal workplace". In a few words, the policy says that (1) agencies shall permit personal religious expression to the greatest extent possible within the requirements of the law, workplace efficiency; (2) agencies must not discriminate based upon religious viewpoints, and (3) religious expression may be directed at other employees as long as the recipient of this expression does not demonstrate that it is unwelcome and reasonable person wouldn't see it as a government endorsement of religion. If you'd like to learn more, just Google "Guidelines on religious exercise and religious expression in the federal workplace".

**MANY, MANY THANKS FOR ALL YOU DO!**

Rachel B. Ramoni, DMD, ScD  
Chief Research and Development Officer  
Office of Research and Development  
Veteran's Health Administration

*Research Saves Veterans' Lives*

AMERICAN  
OVERSIGHT

VA-17-0334-A-000134



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Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)  
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Last Modified: Fri Aug 25 15:37:10 CDT 2017

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image001 <extracted> for Printed Item: 426 Attachment 9 of 12)  
VA-17-0334-A-0004136

AMERICAN  
OVERSIGHT  
*Not from Rache*

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Owner: (b) (6) . </o=va/ou=exchange administrative group (fydibohf23spdlt)  
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Filename: image002.png <extracted>  
Last Modified: Fri Aug 25 15:37:10 CDT 2017

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V A-11-0554-A-000400

image002.png <extracted> for Printed Item: 42

Attachment 10 of 12)

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Last Modified: Fri Aug 25 15:37:10 CDT 2017

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AMERICAN  
OVERSIGHT

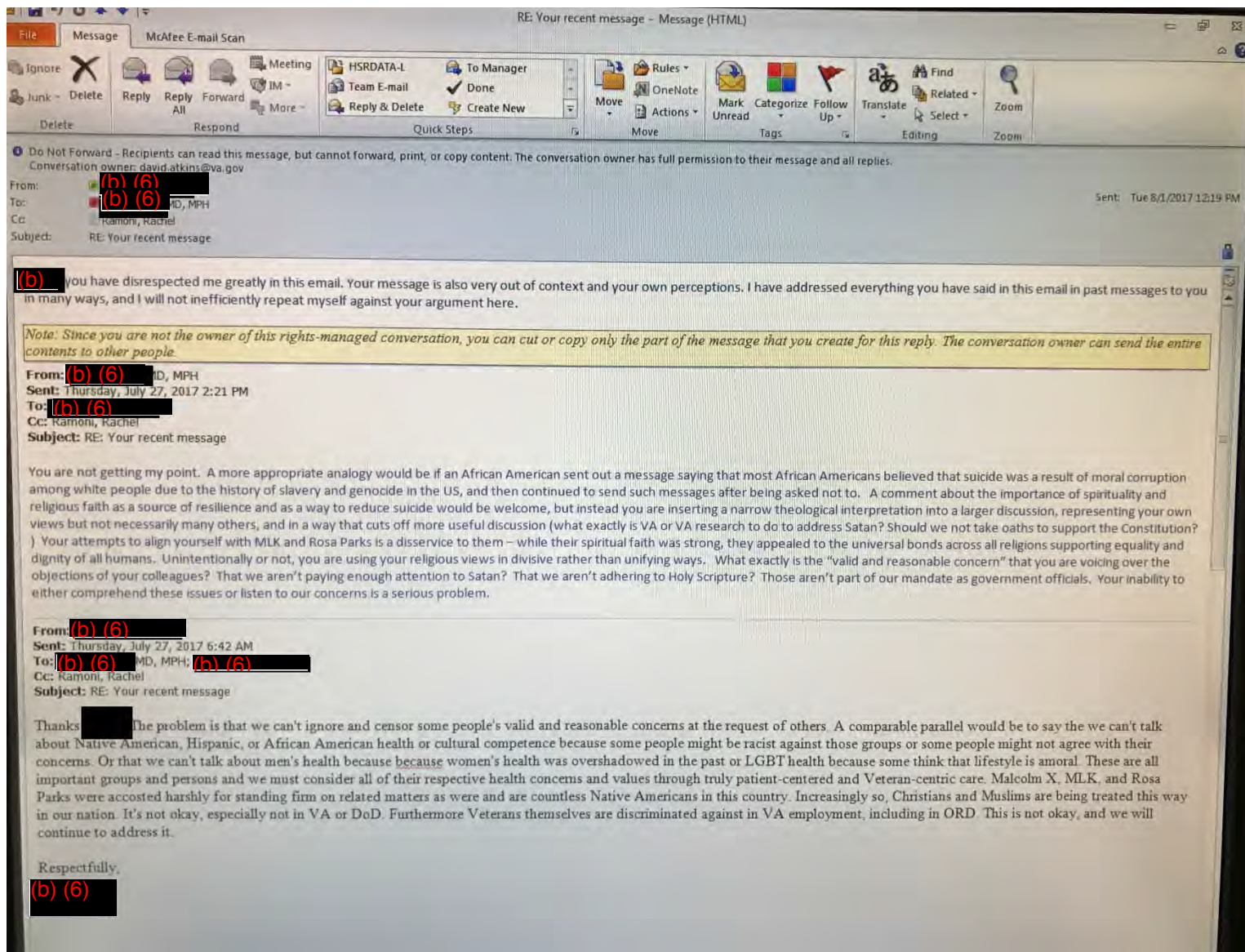
VA-17-0334-A-0000140



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Owner: (b) (6) . </o=va/ou=exchange administrative group (fydibohf23spdlt)  
/cn=recipients/cn=(b) (6), (b) (5) >  
Filename: RE-Your recent message.pdf  
Last Modified: Fri Aug 25 15:37:10 CDT 2017

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See next pages for the rest of this original email message thread. (b) (6) ' reply above was sent as a reply only to (b) (6) on a thread that had included Rachel Ramoni before, and (b) (6) sent it in a way that cannot be forwarded, printed, or otherwise captured within the computer system, so the above is a photo taken of the computer screen it was displayed on. This is another example of how (b) (6) attempts to single out, bully, and disrespect (b) (6) behind figurative closed doors.

**From:** (b) (6)  
**To:** (b) (6) MD, MPH; (b) (6)  
**Cc:** [Ramoni, Rachel](#)  
**Subject:** RE: Your recent message  
**Date:** Thursday, July 27, 2017 6:42:22 AM

---

Thanks (b) (6) The problem is that we can't ignore and censor some people's valid and reasonable concerns at the request of others. A comparable parallel would be to say the we can't talk about Native American, Hispanic, or African American health or cultural competence because some people might be racist against those groups or some people might not agree with their concerns. Or that we can't talk about men's health because because women's health was overshadowed in the past or LGBT health because some think that lifestyle is amoral. These are all important groups and persons and we must consider all of their respective health concerns and values through truly patient-centered and Veteran-centric care. Malcolm X, MLK, and Rosa Parks were accosted harshly for standing firm on related matters as were and are countless Native Americans in this country. Increasingly so, Christians and Muslims are being treated this way in our nation. It's not okay, especially not in VA or DoD. Furthermore Veterans themselves are discriminated against in VA employment, including in ORD. This is not okay, and we will continue to address it.

Respectfully,

(b) (6)

-----Original Message-----

**From:** (b) (6) MD, MPH  
**Sent:** Wednesday, July 26, 2017 05:10 PM Eastern Standard Time  
**To:** (b) (6)  
**Cc:** Ramoni, Rachel  
**Subject:** RE: Your recent message

(b) (6)

I don't think these comments are helping move the discussion forward and I do know these messages make some people uncomfortable, especially when you put out messages that purport to speak for the majority of Christian Veterans (or maybe you were only speaking of those with knowledge of scripture?). I am not sure what you mean when you say the discussion on these matters has changed. I have not changed in my request that you be more respectful of peoples differences and acknowledge that pushing your particular interpretation of religion is alienating your colleagues. There are many varieties of Christianity in this office, in the military and in VA and many non- Christians and non-believers as well, trying to work together for a common goal. These messages undermine that by imposing your own particular views on the process which excludes people who feel differently.

(b) (6)

---

**From:** (b) (6)  
**Sent:** Wednesday, July 26, 2017 11:52 AM



**To:** (b) (6)  
**Cc:** (b) (6) MD, MPH; Ramoni, Rachel  
**Subject:** RE: Your recent message

Respectfully (b) (6) the discussion on these matters has changed. Please consult (b) (6)

---

**From:** (b) (6)  
**Sent:** Wednesday, July 26, 2017 11:49 AM  
**To:** (b) (6)  
**Cc:** (b) (6)  
**Subject:** Your recent message

(b) (6)

Your message below makes me uncomfortable – sending emails like these can be a form of proselytizing which I find inappropriate, discriminatory, and harassing. You have a right to your beliefs, but I find that subjecting people who don't share your beliefs to these types of emails interferes with the work environment, as not everyone may share your perspective and may not welcome or feel comfortable with these types of messages. We have communicated with you several times about the inappropriateness of these messages so please stop sending these immediately.

(b) (6)

---

**From:** (b) (6)  
**Sent:** Wednesday, July 26, 2017 9:46 AM  
**To:** (b) (6) <[@va.gov](mailto:(b) (6)@va.gov)>; VHA CO 10P9H Staff <[VHACO10P9HStaff@va.gov](mailto:VHACO10P9HStaff@va.gov)>  
**Subject:** RE: Is A New Military Oath Really The Best We Can Do To Fight Veteran Suicide?

There are a lot of very good points in this article. A “zero” suicide goal is further problematic as is an “oath” beyond the scientific evidence noted in the article. For example, for Christian Veterans (the majority) well knowledgeable on scripture (a lesser majority) they know that the only time there will be “zero” suicides on this earth are in the second half of Satan’s official 7 year reign (latter 3.5 years), or within Jesus’ Kingdom. Further, “oaths” trip a knowledgeable Christian’s radar as Jesus said, “... do not swear an oath at all... All you need to say is simply ‘Yes’ or ‘No’; anything beyond this comes from the evil one [Satan]” (as recorded in Matthew 5, [NIV]). Of course there is a lot more context to Jesus’ words.

Overall, though, the zero suicide goal and the proposed oath are a good start for this latest stage of discussion, with modification based on research and other guidance. With added knowledge and wisdom from behavioral medicine research, scripture, and other sources, there are a lot of clues for solid solutions and best practices.

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**From:** (b) (6)  
**Sent:** Wednesday, July 26, 2017 8:47 AM

**To:** VHA CO 10P9H Staff

**Subject:** FW: Is A New Military Oath Really The Best We Can Do To Fight Veteran Suicide?

FYI-interesting article on the VA getting to zero initiative and related research:

[http://taskandpurpose.com/new-military-oath-really-best-can-fight-veteran-suicide/?utm\\_source=newsletter&utm\\_medium=email&utm\\_campaign=tp-today&utm\\_content=button](http://taskandpurpose.com/new-military-oath-really-best-can-fight-veteran-suicide/?utm_source=newsletter&utm_medium=email&utm_campaign=tp-today&utm_content=button)

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From: (b) (6) HAMVAMC  
</o=va/ou=visn 06/cn=recipients/cn=(b) (6), (b) (5)>  
To: Shulkin, David J., MD  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
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(b) (6) HAMVAMC </o=va/ou=visn  
06/cn=recipients/cn=(b) (6), (b) (5)>  
Cc:  
Bcc:  
Subject: FW: VA Stories of Note: July 28 – August 3, 2017  
Date: Mon Aug 21 2017 09:27:12 CDT  
Attachments:

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Dear Secretary Shulkin and (b) (6),

I am sending this message to let you know that I am highly disappointed that the Department of Veterans Affairs would consider Breitbart News appropriate for dissemination to veterans and staff of all stripes.

I have felt this for some time and with the recent events in Charlottesville, Virginia, etc., I felt it past time that I said something.

I do not believe that Breitbart represents the ICARE principles or any other positive example that VA employees are to abide.

I hope that you will respond to me and let me know your position on this matter.

Thanking you in advance -

(b) (6), (b) (5), Pharm.D.

Hampton VAMC

Phone: 757-722-9961, ext. (b) (6), (b) (5)

Fax: 757-315-(b) (6), (b) (5)

(b) (6)@va.gov

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From: US Department of Veterans Affairs  
Sent: Friday, August 04, 2017 12:31 PM  
To: VAAIUUsers <VAAIUUsers@va.gov>  
Subject: VA Stories of Note: July 28 - August 3, 2017

A MESSAGE FROM THE OFFICE OF PUBLIC AND INTERGOVERNMENTAL AFFAIRS

VA Stories of Note: July 28 - August 3, 2017

USA Today (Video), August 3: Trump touts Veterans Affairs 'tele-health' program with new appointment scheduling application President Trump touted a new program to increase veterans' electronic access



to medical care as part of a broader tele-health push at the Department of Veterans Affairs. The initiative connects veterans with health providers via mobile phones or computers, and is intended to improve medical care especially for those needing mental health and suicide prevention services, Trump said.

Associated Press, August 3: Trump promotes technology to improve veterans' health care President Donald Trump announced new efforts Thursday to use technology to improve veterans' health care, saying the programs will greatly expand access, especially for mental health care and suicide prevention. Veterans living in rural areas will also benefit, he said. Initiatives include using video technology and diagnostic tools to conduct medical exams. Veterans also will be able to use mobile devices to make and manage appointments with Veterans Administration doctors.

NBC News (Video), August 3: Trump Touts Improvements to Mobile Health Care System for Veterans President Donald Trump celebrated improvements to the mobile system veterans can use to access health care Thursday, touting an "historic breakthrough" in Department of Veterans Affairs technology that makes it easier for patients to schedule and receive care remotely. The new tools expand the VA's existing 'Telehealth Services' with a new application that lets veterans schedule appointments from their mobile phones (Veteran Appointment Request, or VAR) and VA Video Connect, which connects veterans with health specialists.

Washington Post (Video), August 3: Trump introduces new telehealth initiative for veterans President Trump joined Veterans Affairs Secretary David Shulkin to announce a new telehealth program for veterans on Aug. 3. "This will significantly expand access and care for our veterans, especially for those who need help in the area of mental health," he said.

WIRED (New York, N.Y.), August 3: The VA's New App Tries To Reach Vets Wherever They Live Department of Veterans Affairs operates one of the country's largest telemedicine programs, with some 700,000 veterans receiving medical care and advice via their computers and mobile devices last year alone. Now, the VA is announcing a drastic expansion of that program with the launch of a new tool called VA Video Connect, which it intends to expand to every VA hospital across the country.

United Press International (Washington, DC) August 3: Trump, VA chief Shulkin announce new telehealth services President Donald Trump on Thursday praised new tools allowing veterans mobile access to their doctors as a "historic breakthrough." Trump and Veterans Affairs Secretary David Shulkin announced an expansion of telehealth services for veterans, including a new mobile app allowing patients to make and change appointments.

KTVL (CBS-10, Video) (Medford, Ore.), August 3: Grants Pass veteran helps unveil VA technology to White House, Pres. Trump Thursday morning, Dr. David Shulkin, Secretary of Veterans Affairs, helped present Telehealth to President Donald Trump with the help of an outpatient clinic and patient in Grants Pass. Albie Amescua, a Coast Guard veteran living in Grants Pass, met with both men via Telehealth - a technology that helps Amescua receive care he needs from the VA, even though his doctor is based in Boise, Idaho.

Hugh Hewitt Show, Aug 1: Secretary of Veterans Affairs Dr. David Shulkin One of the most interesting people in the United States Cabinet is Dr. David Shulkin, who is the Secretary of Veteran Affairs, and has been at the VA since taking the number two position there under President Oibama. He was promoted by President Trump, confirmed unanimously because of his private sector experience with patient-centered care. He was a CEO of Beth Israel Medical Center in New York.

Breitbart (Audio), Aug 1: Secretary Shulkin on V.A. Modernization: Wait Times Posted Online, Same-Day Service for Emergencies Secretary of Veterans Affairs Dr. David Shulkin appeared on Tuesday's Breitbart News Daily to discuss reforms made at the V.A. on his watch, the challenges that still remain, the state of health care reform for the private sector, and the emotional Medal of Honor ceremony for Vietnam War Army medic James McCloughan.

New York Times, Aug 2: With Rare Unanimity, Senate Sends G.I. Bill Expansion to Trump Advocates for the legislation say it could directly affect more than half a million veterans over the next 15 years. But the bill's beneficiaries are not limited to veterans. Its passage presents President Trump with another modest legislative victory in one of the few areas he has been able to find them: veterans issues. And to congressional lawmakers who have struggled to advance Republican priorities despite the party's control of both chambers...

Military Times, Aug 2: New GI Bill passes Senate The Harry W. Colmery Veterans Education Assistance Act of 2017 has garnered strong bipartisan support in Congress, where lawmakers have worked to fast-track the bill to the president's desk. Senators passed the legislation by voice vote Wednesday, less than three weeks after the Forever GI Bill, as it's become known, was introduced in the House of Representatives.

Waco Tribune-Herald (Waco, Texas), Aug 2: Scientists at Waco VA pioneering new technology for brain scans But two scientists at the Center of Excellence for Research on Returning War Veterans in Waco are making waves nationally by pioneering a data-driven approach. Veterans referred to the center from Veterans Affairs hospitals in Waco, Temple and Austin receive multiple MRI-generated brain scans over several hours and days, giving scientists a chance to pinpoint subtle changes that may produce symptoms.

Valley News (White River Junction, Vt.), July 29: VA Working to Prevent Suicides Valerie Pallotta, whose son Joshua died by suicide in 2014, isn't sure what, if anything, could have prevented her son's death at the age of 25. Josh Pallotta, a veteran of the Vermont National Guard, struggled with post-traumatic stress disorder and brain injuries after returning from a tour in Afghanistan, a tour that included the deaths of two other members of his unit.

PLEASE PRODUCE LOCALLY FOR ALL THOSE WHO DO NOT ROUTINELY ACCESS EMAIL DUE TO THEIR SPECIALTIES.

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From: (b) (6), (b) (5) @hotmail.com>  
To:  
Cc:  
Bcc:  
Subject: [EXTERNAL] NEJM articles on liver imaging and biopsy and CMV pneumonia and dermatomyositis/Lancet summary on EBOV in West Africa  
Date: Thu Aug 24 2017 06:51:36 CDT  
Attachments: NEJMcpc1616402.pdf  
NEJMr1610570.pdf  
PIIS1473-3099(17)30234-7.pdf

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Dear Residents and Colleagues,

Here are two interesting articles about the liver and lungs from today's NEJM:

1. CPC about a woman with dermatomyositis and CMV pneumonitis from all her immunosuppression. The CT images show 'mosaic lung' but the images shown are poor examples. See the first pdf ending in ...402 attached above to view the CPC images. Here is the Radiopaedia discussion of mosaic lung with better images:

<https://radiopaedia.org/articles/mosaic-attenuation-pattern-in-lung>

Mosaic attenuation pattern in lung | Radiology Reference ...  
radiopaedia.org

Mosaic attenuation is the description given to the appearance at CT where there is a patchwork of regions of differing attenuation. It is a non-specific finding ...

2. Review Article about liver imaging and biopsy in clinical practice. See the second pdf ending in ... 570 attached above. The imaging test of choice for focal lesions in the liver is MRI. The best measure of non-invasive fibrosis according to the authors is elastography for which MRI is a part. The downsides of liver biopsy are discussed. Figure 3 is a chart of the specific appearances and enhancement features of various focal liver lesions on MRI.

Here is the Radiopaedia article on focal liver lesions so you can compare the NEJM chart to another



source (I do not do liver MRI so I cannot verify the NEJM Figure 3):

<https://radiopaedia.org/articles/liver-tumours>

Liver tumours | Radiology Reference Article | Radiopaedia.org  
radiopaedia.org

Liver tumours, like tumours of any organ can be classified as primary or secondary. Metastases Liver metastases are by far the most common hepatic malignancy, with ...

3. There is also a Lancet Infectious Disease article online this morning that summarizes what was learned clinically from the EBOV epidemic in West Africa. Ring vaccination works is the key conclusion. See the PHS pdf attached above.

(b) (6)  
(b) (5) M.D.

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Owner: Coffey, Georgia </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)  
Filename: image004.jpg  
Last Modified: Fri Aug 18 14:16:07 CDT 2017

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image004

for Print

Item: 60

Attachme

of 3)



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From: (b) (6) </o=va/ou=exchange  
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(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)  
To: Shulkin, David J., MD  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)  
Cc:  
Bcc:  
Subject: Thank you  
Date: Thu Aug 17 2017 14:40:39 CDT  
Attachments:

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Dear Honorable Dr. David Shulkin,

My name is (b) (6) MD. I am the son of Coptic Egyptian immigrants who came to this country in the late 60's to escape religious persecution and discrimination.

I was born and raised in New Jersey and have always had a tremendous love and appreciation for this beautiful country and what it has provided for my family.

I was unable to join the military, so I did the next best thing and joined the Veterans' Administration to serve those who fought for freedom, democracy, and the great values of the United States of America. I was very disappointed by the recent events in Charlottesville, Virginia. What I found even more disturbing was to see one of our veterans of the 82nd Airborne Division standing with a Nazi salute. This has created great angst and disappointment for myself, my Jewish colleagues, and other minority colleagues who work diligently side by side every day to serve our veterans. I am cognizant of our Hippocratic oath "I will use treatment to help the sick according to my ability and judgment...." I and others will continue to honor our Hippocratic oath to treat all veterans, even though a few may harbor evil hatred views toward us. I would like to bring to your attention it's not only a few veterans that harbor these views, but some employees at the VAMC also have these sick views. I have worked at four VAMCs and can share with you the stories of discrimination that I and others have dealt with. I truly appreciate and commend you for standing up for honorable values and morality. <http://www.jta.org/2017/08/17/news-opinion/politics/va-secretary-david-shulkin-says-charlottesville-rally-dishonored-veterans>.

We look forward to your continued leadership and guidance in fulfilling President Lincoln's mission statement consistent with the VAMC core values.

Thank you for your service,

(b) (6) MD FACP



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From: Americans for Limited Government  
<media@limitgov.org>  
To: Shulkin, David J., MD  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Cc:  
Bcc:  
Subject: [MARKETING] [EXTERNAL] Obama did not tear down the Robert E. Lee Memorial on federal property either  
Date: Fri Aug 18 2017 08:23:54 CDT  
Attachments:

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Why didn't the media call Obama out?

August 18, 2017

Permission to republish original op-eds and cartoons granted.

Obama did not tear down the Robert E. Lee Memorial on federal property either

The Arlington House, the Robert E. Lee Memorial, has been a part of the National Park Service as a national monument since 1955, when Congress designated it. The building was the household of Confederate general Robert E. Lee, built in 1803. It was never torn down and has remained for more than 200 years.

Big Business loves Big Government

While the 115th Congress remains at a standstill on overhauling Obamacare, there is a much lesser known, yet important, ongoing fight in health care: the battle pitting open competition against monopolization of the contact lens market.

The Hill: Assange meets US congressman, vows to prove Russia did not leak him documents

Julian Assange told a U.S. congressman on Tuesday he can prove the leaked Democratic Party documents he published during last year's election did not come from Russia and promised additional helpful information about the leaks in the near future.

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Obama did not tear down the Robert E. Lee Memorial on federal property either



By Robert Romano

The Arlington House, the Robert E. Lee Memorial, has been a part of the National Park Service as a national monument since 1955, when Congress designated it. The building was the household of Confederate general Robert E. Lee, built in 1803. It was never torn down and has remained for more than 200 years.

Notably, the Robert E. Lee Memorial kept its designation as a national monument all throughout the Obama administration from 2009 to 2016. Former President Barack Obama never proposed removing it.

So, why honor Lee with a national memorial? Why wasn't it torn down during the last administration? In reality, this is not as controversial as the current post-Charlottesville, Va. national climate would have you believe. At the time, in 1955, Congress resolved that "after Appomattox [Lee] fervently devoted himself to peace, to the reuniting of the Nation."

Today, the National Park Service website on the Arlington House states its reason for being a national monument: "Arlington House is the nation's memorial to Robert E. Lee. It honors him for specific reasons, including his role in promoting peace and reunion after the Civil War. In a larger sense, it exists as a place of study and contemplation of the meaning of some of the most difficult aspects of American History: military service; sacrifice; citizenship; duty; loyalty; slavery and freedom."

After the horrors of the Civil War, Lee was honored precisely because of the 1865 surrender at Appomattox, which both symbolized and realized the restoration of the Union. Famously, the Union and Confederate soldiers saluted each other at the ceremony, affirming the restoration of national brotherhood as well.

This was no easy project, and Lee's role was pivotal to bringing a close to this dark chapter of American history. He could have gone out in a blaze, or refused terms even in defeat, potentially making national reconciliation more difficult. Instead, Lee ended the rebellion and surrendered. He was never arrested for treason and later went on to serve as President of Washington College.

The issue of former Confederate soldiers was resolved with mass amnesties and limited pardons by President Abraham Lincoln and later full pardons by President Andrew Johnson in 1868.

The leniency toward Lee was obviously bigger than the general. Ultimately, the Civil War was resolved by allowing the rebelling states to reenter the Union and participate in the political process, with representation in Congress and the Electoral College.

One of the first states was Louisiana, which had a new constitution and had committed to ratifying the 13th Amendment abolishing slavery. But some critics wanted Louisiana to go further, extending the franchise of voting rights to blacks. However, President Lincoln intervened, in his final public address on April 11, 1865, saying, "Grant that he desires the elective franchise, will he not attain it sooner by saving the already advanced steps toward it, than by running backward over them?... [I]f we reject Louisiana, we also reject one vote in favor the proposed amendment to the national Constitution... Can Louisiana be brought into proper practical relation with the Union sooner by sustaining or discarding her new State Government?"

In short, states were brought back into the Union under the agreement to abolish slavery, with forgiveness to confederate soldiers, and with an understanding that other changes, such as citizenship and voting rights would come later. And they did in the 14th and 15th Amendments. After a brutal war, this was the national reconciliation that could be achieved at the time. State sanctioned-segregation came later, sadly affirmed by Plessy v. Ferguson (1896), almost thirty years after Lee died, and set progress back decades.

But, in its totality, the contribution made by Lee at the end of the war was notable to such an extent that

Congress saw fit to honor him with a national memorial, despite his pivotal role in the rebellion, which stands to date. Now, Congress might see fit to revisit that issue. As a part of that debate, we might consider how much more difficult ending the Civil War and achieving national reconciliation would have been without the nobility of Lee.

We must also consider that by rejecting Lee, we risk reopening national wounds by rejecting the delicate terms that ended the war. Do we no longer honor the end of the Civil War and Lee's surrender? Do we wish to fight it again? Really? Has history taught us nothing?

This is a moment to pause and reflect on that history and learn from it — not erase it.

President Donald Trump is doing the right thing by continuing the Obama policy of keeping the Confederate war memorials on national parks open. You should visit them and learn about this time in American history.

Overall, the national Lee Memorial reminds the nation of the legacy of leniency pursued by Lincoln and later Johnson that helped heal the nation by reducing violence on all sides — leadership we sorely need today in the aftermath of the tragedy at Charlottesville, Va.

Robert Romano is the Vice President of Public Policy of Americans for Limited Government.

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Big Business loves Big Government

By Peter Hong

While the 115th Congress remains at a standstill on overhauling Obamacare, there is a much lesser known, yet important, ongoing fight in health care: the battle pitting open competition against monopolization of the contact lens market.

For years, health care giant Johnson & Johnson had the contact lens manufacturing market cornered, due in large part to the benefits of a government-created monopoly and the substantial kickbacks it gave optometrists on sales of its Acuvue brand lenses.

Until 2004, optometrists were not obligated to give patients a copy of their prescriptions, stripping from contact lens wearers control about where to shop. As a result, consumers generally obtained their lenses directly from eye doctors at higher prices. This pattern favored large, established lens manufacturers like Johnson & Johnson and their cozy backroom deals with optometrists.

To level the playing field, Congress enacted the "Fairness to Contact Lens Consumers Act" (FCLCA), which included, among other reforms, a requirement that doctors automatically provide their patients with their prescription free of charge following a contact lens fitting. It also prevents them from delaying third-party sales for indefinite amounts of time. Because doctors could no longer steer their patients to favored lens brands, new entrants, including Walmart and online retailers, began raising the level of competition into the marketplace.

Even with the entry of new competition, Johnson & Johnson still controls a 40% share of the contact

lens market. Much of this is due to the fact that the FCLCA reforms have not been fully enforced. A poll commissioned this year by Consumer Action reveals that nearly one-third (31%) of contact lens consumers still do not receive their prescription from their doctor following an exam. Not surprisingly, 72% of contact lens consumers surveyed purchase contact lenses at their eye doctors' offices, while only 24% of surveyed consumers purchase lenses from online sites.

The Federal Trade Commission (FTC), the federal agency tasked with breaking up unfair and anti-competitive monopolies, is currently in the process of finalizing its rule for ensuring greater market competition. In addition to ensuring that prescribers provide patients with complete prescriptions, it also requires doctors to verify or provide prescription information to third-party contact lens sellers, like 1-800-CONTACTS or Lens.com.

Just this week, Senators Orrin Hatch (R-UT), Chairman of the powerful Senate Finance Committee, and Richard Blumenthal (D-CT) sent a letter to Acting FTC Chairwoman Maureen Ohlhausen asking the agency to finalize its rule. "Federal law correctly bars contact lens consumers from obtaining their lenses without a prescription," the senators wrote. "Yet, at the same time, eye care providers that issue prescriptions can also dispense the contact lenses they prescribe, creating an inherent conflict of interest."

The Washington professionals representing the optometrists and big manufacturers are fighting back. They persuaded Congressmen Leonard Lance (R-NJ) and Bobby Rush (D-IL) to lead the effort urging the FTC to withdraw the rule. Not surprisingly, Johnson & Johnson and another contact lens manufacturing giant, Allergan, were the second and third largest contributors to Lance's campaign in the 2016 cycle.

The lobbies for the optometrists and contact lens power players are also pursuing legislative options to further restrict competition. Last year, they persuaded members of the House and Senate to introduce the "Contact Lens Consumer Health Protection Act" (CLCHPA). While the measure failed to pass in the 114th Congress, you can bet its proponents are hard at work to revive it this year.

The measure would have required all contact lens sellers to provide methods of communications like fax numbers and landline numbers — points of contact which many online vendors don't have. Under the bill, doctors would have been reinstated their indefinite approval cushion for third-party orders, meaning that eye doctors could again block the sale of lenses from any disfavored vendors simply by stalling. In other words, all the progress made toward establishing free and open competition in the contact lens marketplace would be for naught.

The arguments against open competition are misleading at best. Most center around contrived notions about alleged health dangers posed by purchasing contact lenses from alternative retailers. These claims have been debunked thoroughly and repeatedly by a number of different expert sources, including the FTC, the Centers for Disease Control and Prevention (CDC), and the optometrist's own research arm.

For instance, in its rule proposal, the FTC concluded there was no increased risk of buying contact lenses from alternative retailers, stating: "the Commission has not seen reliable empirical evidence to support a finding that such sales are contributing to an increased incidence, or increased risk, of contact lens-related eye problems."

Even the optometrists' own research organization can't back up its specious claims. According to a study published by the American Academy of Optometry (AAO), "the purchase location of soft contact lens wearers had limited impact on known risk factors for soft contact lens-related complications." Notably, this study, using data from the CDC, was conducted by an optometric research organization formed by the AAO and funded by a grant from Alcon, a leading contact lens manufacturer.

Free markets only work efficiently when they are open to free and fair competition. Monopolies, particularly those created or fueled by misguided public policy, are bad news for the economy, potential



new entrants, and especially consumers. When Congress returns in September, it should focus on overhauling the country's biggest failing health care monopoly – Obamacare – and avoid interfering with the efforts of the FTC to ensure free and open competition in the contact lens market.

Peter Hong is a contributing editor at Americans for Limited Government

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ALG Editor's Note: In the following piece from The Hill, John Solomon talks to Rep. Rohrabacher about his meeting with Julian Assange and his claim to have proof Russia did not hack the DNC.

The Hill: Assange meets US congressman, vows to prove Russia did not leak him documents

By John Solomon

Julian Assange told a U.S. congressman on Tuesday he can prove the leaked Democratic Party documents he published during last year's election did not come from Russia and promised additional helpful information about the leaks in the near future.

Rep. Dana Rohrabacher, a California Republican who is friendly to Russia and chairs an important House subcommittee on Eurasia policy, became the first American congressman to meet with Assange during a three-hour private gathering at the Ecuadorian Embassy in London, where the WikiLeaks founder has been holed up for years.

Rohrabacher recounted his conversation with Assange to The Hill.

"Our three-hour meeting covered a wide array of issues, including the WikiLeaks exposure of the DNC [Democratic National Committee] emails during last year's presidential election," Rohrabacher said, "Julian emphatically stated that the Russians were not involved in the hacking or disclosure of those emails."

Pressed for more detail on the source of the documents, Rohrabacher said he had information to share privately with President Trump.

"Julian also indicated that he is open to further discussions regarding specific information about the DNC email incident that is currently unknown to the public," he said.

U.S. intelligence has insisted it has solid proof — which it has not made public — that Russia was behind last year's election hacks that embarrassed Democrats, including unflattering revelations about nominee Hillary Clinton and her campaign chairman, John Podesta, whose personal email account was also hacked.

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From: (b) (6) </o=va/ou=va  
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To:  
Cc:  
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Subject: Secretary's Stand-up - OPIA - August 31  
Date: Thu Aug 31 2017 07:30:03 CDT  
Attachments: 170831\_Brief.pptx

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Good Morning

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# VA Secretary's Stand-Up Brief

31 August 2017

## Executive Summary

National coverage included two interviews with Secretary Shulkin. Regional coverage followed vandalism at the Springfield National Cemetery and the trial of a former Leavenworth VA physician assistant. Local outlets continued to follow the Department's response to Hurricane Harvey.

Storyline	Outlets	Analysis	Trend	MyVA Priority
Sec. Shulkin interview round-up	<a href="#">Christian Broadcasting Network, Steve Gruber Show, KTAR (CMN)</a>	Secretary Shulkin appeared on CBN's 'Faith Nation' program to discuss recent legislation that has advanced VA reform. <i>The Steve Gruber Show</i> posted its Tuesday interview with the Secretary. <i>KTAR</i> reported on its own interview with Dr. Shulkin and also focused on recent legislation.	<b>Emerged</b>	Experience / Access
Springfield National Cemetery Confederate monument vandalized	<a href="#">AP, Springfield News-Leader, KYTV (NBC), KOLR (CBS)</a>	The VA-related coverage of this storyline centered on questioning why the vandalism occurred despite recently hired security and the VA response to that inquiry. A divergent narrative followed Facebook post made by a state legislator that called for the vandals to be "& hung from a tall tree with a long rope" and drew attention from VA-related narratives.	<b>Emerged</b>	Experience
Fmr. Leavenworth VA physician assistant trial	<a href="#">AP, Topeka Capital-Journal</a>	AP previewed the trial of the former physician assistant charged with physically abusing patients and gave a brief summary of the storyline. <i>Capital-Journal</i> reported that Mark Wisner was convicted of 2 felonies and three misdemeanors after a three day trial.	<b>Long-term</b>	Experience
VA involvement in Hurricane Harvey	<a href="#">Commercial Appeal, WBRC (FOX), WIAT (CBS)</a>	Local coverage of the hurricane sustained and focused on the narrative that followed evacuation of Texas patients to different hospitals.	<b>Sustained</b>	Access
VA animal testing	<a href="#">Plain Dealer</a>	<i>Plain Dealer</i> profiled the history of VA animal testing and looked at the differing positions of animal rights activists and some VSOs.	<b>Long-term</b>	Other
Whistleblower discusses current state of Manchester VA	<a href="#">NHPR</a>	NHPR interviewed Doctor Stewart Levenson, one of those dozen whistleblowers who went public last month, who claims that the facility currently has a "leadership void" and that "none of the major departments has stable leadership at this point." Topics discussed include the composition of the task force, Secretary Shulkin's reaction to whistleblower concerns, and suicide prevention month.	<b>Emerged</b>	Experience

VA-17-0334-A-000063



# VA Secretary's Stand-Up Brief

31 August 2017

## Social Media Takeaway

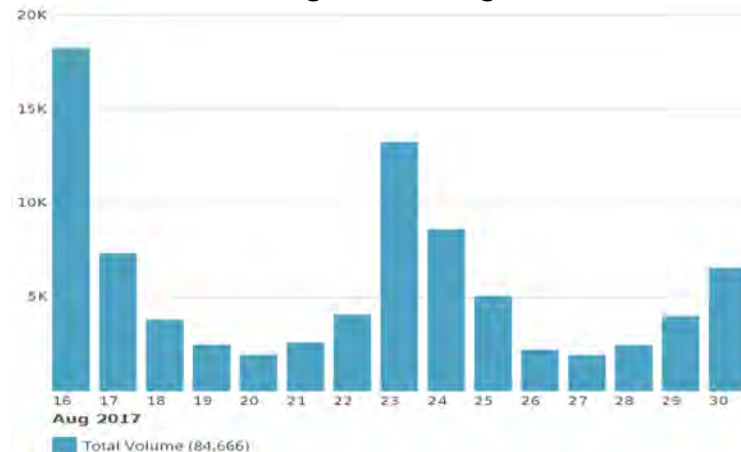
Secretary Shulkin's account was the main driver of activity during the period with posts that highlighted VA's response to Hurricane Harvey.

## Key Points

- Secretary Shulkin posted five of the top ten retweeted posts. The [top post](#) from @SecShulkin, and also the top-retweeted of the period gained over 1.7k RTs and constituted 40 percent of social media volume alone – it was also the main driver of #HurricaneHarvey (2k mentions). Beyond retweeted posts, the Secretary was also the most prominent account during the period, garnering 1.2k mentions in user's posts and other retweets.
- Retweets of the Secretary's posts were also responsible for the additional mentions of the #HurricaneHarvey, outside retweets of his leading tweet. The hashtag also far outstripped other tags associated with the Hurricane, #Harvey and #Texas, which each received only 40+ mentions.
- The main VA Facebook page gained notable user engagement with a [video](#) that profiled Veteran Jessie Fox, who is the owner/operator of a BBQ restaurant in Clarksville, Tenn. The video gained roughly 10k more views than is typical for the VA page.
- A 24 August post from [USA Today](#), linking to their profile of a woman who is the beneficiary of the [last civil war pension](#), saw an uptick activity and gained 120+ additional retweets – nearly a third of its total retweets to date.

## Twitter and Facebook Volume:

16 August – 30 August



## Notable Social Media Items

Platform	Item	Relevance
Twitter	<a href="#">Post: Mobile Vet Center set up to help #Veterans impacted by hurricane</a>	40% of Volume
Twitter	@SecShulkin	1.2k Mentions
Facebook	<a href="#">Army Veteran Jessie Fox operates Fox's BBQ in Clarksville, Tennessee, and enjoys serving delicious food to fellow soldiers and community.</a>	1.4k Reactions, 470+ Shares, 35k Views



Dr. David J. Shulkin  
@SecShulkin

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From @VAHouston: "It's a privilege to care for our nation's heroes" [blogs.va.gov/VAntage/40632/](#) ... via [#VAntagePoint](#) #HurricaneHarvey



Dr. David J. Shulkin  
@SecShulkin

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Thanks to our employees and volunteers who continue to care for #Veterans throughout this disaster [statesman.com/news/local-mil](#) ... via @statesman

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To: Shulkin, David J., MD  
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Cc:  
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Subject: [MARKETING] [EXTERNAL] Martin Luther King condemned the violence on both sides,  
too  
Date: Thu Aug 17 2017 08:20:13 CDT  
Attachments:

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Why is the media condemning Martin Luther King Jr?

August 17, 2017

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Martin Luther King condemned the violence on both sides, too  
Martin Luther King, Jr. deplored the violence on all sides of the national pursuit for racial equality, condemning both the "terror of extremist white violence" and at the same time those who resorted to riots to end racial oppression and segregation. How is that different from how President Donald Trump responded to the violence in Charlottesville, Va.?

Only 58 percent?

College is supposed to prepare young people for the world. Students are supposed to gain knowledge and learn skills that prepare them for a career, while challenging their minds. Somewhere along the line that changed. Colleges have become indoctrination factories reminiscent of the Soviet Union, and this is influencing the IDEA of college. In fact, a recent Pew poll shows "58 percent of Republicans and Republican-leaning independents say colleges and universities have a negative effect on the way things are going in the country." What caused the change?

Big labor fights for big government

The California legislature is currently considering legislation which would make it nearly impossible for most county governments to hire companies and nonprofits to deliver public services. The bill, AB 1250, was introduced by a former Service Employees International Union (SEIU) boss, and SEIU is one of its chief proponents.

CBS News: Iceland aborts almost 100 percent of at-risk children for Down syndrome, U.S. aborts 67 percent.

With the rise of prenatal screening tests across Europe and the United States, the number of babies born with Down syndrome has significantly decreased, but few countries have come as close to eradicating Down syndrome births as Iceland. Since prenatal screening tests were introduced in Iceland in the early 2000s, the vast majority of women -- close to 100 percent -- who received a positive test for Down syndrome terminated their pregnancy.

Martin Luther King condemned the violence on both sides, too

By Robert Romano

Someone has to be the adult in the room.

Whenever President Donald Trump — or any political leader — stands up to condemn all of the violence at a national tragedy such as Charlottesville, Va. regardless of the causes, political or otherwise, those calls should be embraced, lest the result be that some forms of political violence be justified — and perpetuated as a consequence.

That was what Dr. Martin Luther King, Jr. preached. He said, "Hate begets hate; violence begets violence; toughness begets a greater toughness. We must meet the forces of hate with the power of love... Our aim must never be to defeat or humiliate the white man, but to win his friendship and understanding."

King deplored the violence on all sides of the national pursuit of racial equality. In his book, "Where do we go from here: Chaos or community?" King condemned the "terror of extremist white violence" and at the same time gave an equal share of the blame for violence to those who resorted to riots to end racial oppression and segregation: "in several Northern and Western cities, most tragically in Watts, young Negroes had exploded in violence. In an irrational burst of rage they had sought to say something, but the flames had blackened both themselves and their oppressors."

While King understood why the riots occurred — he called them the "language of the unheard" — and yet he did not justify them, instead saying, "riots are socially destructive and self-defeating" and "there's no practical or moral answer in the realm of violence" and "there is no violent solution" to social injustices.

Was King morally equating those who perpetuated racial injustice and those who opposed it, as Trump is now accused? No. But he was saying resorting to violence to achieve political ends, regardless of the motive, was unquestionably immoral, even in the pursuit of racial justice. That is all.

But it was not simply a message of non-violence as its own end. King never lost sight of his goals: "it is not enough for me to stand before you tonight and condemn riots. It would be morally irresponsible for me to do that without, at the same time, condemning the contingent, intolerable conditions that exist in our society." He urged legislation via our political institutions, not physical confrontation, to resolve the evils of segregation.

King was being the adult in the room. He was right. While the nation was tearing itself apart over a true injustice, government-forced racial segregation, he pursued non-violent, political means to achieve the changes he sought. In the face of racial violence, he preached a non-violent response. He kept the moral high ground. His view was that violence would only lead to more violence, and so brokered no quarter for those who resorted to it — whether they were fighting for or against racial injustice.

At question today is whether President Trump should have condemned not only the violence in Charlottesville, Va. perpetrated by hateful white supremacists attending the rally opposing the removal of a statue of Confederate general Robert E. Lee — including the tragic murder of Heather Heyer by James Fields — but also the anti-fascists ("Antifa") counter-protesters who attended and engaged in street fights with the protesters.

On Twitter on Aug. 12, Trump deplored the violence, writing in his first response to the tragedy at 1:19

p.m., "We ALL must be united [and] condemn all that hate stands for. There is no place for this kind of violence in America. [Let's] come together as one!"

Later in the day, he said at a speech in Bedminster, N.J. at 3:33 p.m., "we're closely following the terrible events unfolding in Charlottesville, Virginia. We condemn in the strongest possible terms this egregious display of hatred, bigotry and violence, on many sides. On many sides. It's been going on for a long time in our country. Not Donald Trump, not Barack Obama. This has been going on for a long, long time. It has no place in America. What is vital now is a swift restoration of law and order and the protection of innocent lives. No citizen should ever fear for their safety and security in our society, and no child should ever be afraid to go outside and play, or be with their parents, and have a good time."

Here, Trump had condemned all of the violence that occurred at the event including the murder by Fields and the violence between the protesters and the counter-protesters — and was roundly condemned, apparently by those who prefer some forms of violence over others.

To be clear, based on Charlottesville court records, attendees from both sides of the protest were arrested for assault and other charges, including Fields. For example, Troy Dunigan, was arrested for throwing objects at the Nazi protesters. Jacob Leigh Smith was arrested for attacking a journalist.

Journalist Sheryl Gay Stolberg reported violence on both sides on Twitter on Aug. 12, "The hard left seemed as hate-filled as alt-right. I saw club-wielding 'Antifa' beating white nationalists being led out of the park."

So, indisputably, there was violence on both sides, neither of which can be justified, and Trump condemned it all. So too would have King, who lived through far worse, and through it all condemned all of the violence, even the violence that was committed on his cause's behalf.

That is not to paint Trump as some sort of pacifist or advocate of non-violent resistance. He's not. Not at all. But neither is he irresponsible to abhor the violence of Charlottesville — all of it — and urge all sides to stand down. He has a responsibility to restore civil order.

That is a demonstration of leadership at an extremely difficult moment. That is not always the popular path, the expedient one. King too was criticized in his lifetime by those who thought violence was warranted. But sometimes leadership means doing what others are afraid to do. King stood above it all, saying, "Violence as a way of achieving racial justice is both impractical and immoral... Violence is impractical because it is a descending spiral ending in destruction for all. It is immoral because it seeks to humiliate the opponent rather than win his understanding: it seeks to annihilate rather than convert. Violence is immoral because it thrives on hatred rather than love. It destroys community and makes brotherhood impossible. It leaves society in monologue rather than dialogue. Violence ends up defeating itself. It creates bitterness in the survivors and brutality in the destroyers."

It also happens to be the law, where regardless of motive, physical violence cannot be tolerated except in self-defense. What if Trump had done the opposite and condemned the criminal violence of some while condoning the violence of others? Surely, the easy path would be to ignore those who attacked attendees of the Charlottesville protest, and simply focus on Fields' murder.

But as the nation's foremost law enforcement officer, Trump, the head of the executive branch, the President is obligated to apply the law equally. A police officer would have to behave no differently. White supremacist or Antifa, if you get violent, you're going to jail. That is the law, and the President is supposed to enforce the law and set an example for all Americans — those with whom he agrees and disagrees. It would be irresponsible and wrong to condone instigating violence, taking matters into one's own hands, whether against an anti-fascist or a Nazi.

At a very horrible moment in our history, on Aug. 12, the President demonstrated moral clarity. He wrote on Twitter at 5:19 p.m., "We must remember this truth: No matter our color, creed, religion or political party, we are ALL AMERICANS FIRST." He later expressed condolences to the family of



Heyer, and also of the officers who were killed in the line of duty in Charlottesville.

On Aug. 14, at the White House, Trump made an additional speech announcing a Justice Department civil rights investigation into the violence, stating, "No matter the color of our skin, we all live under the same laws, we all salute the same great flag, and we are all made by the same almighty God. We must love each other, show affection for each other, and unite together in condemnation of hatred, bigotry, and violence. We must rediscover the bonds of love and loyalty that bring us together as Americans. Racism is evil. And those who cause violence in its name are criminals and thugs, including the KKK, neo-Nazis, white supremacists, and other hate groups that are repugnant to everything we hold dear as Americans. We are a nation founded on the truth that all of us are created equal. We are equal in the eyes of our Creator. We are equal under the law. And we are equal under our Constitution. Those who spread violence in the name of bigotry strike at the very core of America."

Then on Aug. 15, at Trump Tower in New York City, Trump again blamed "both sides" for the violence, saying, "You had a group on one side and you had a group on the other and they came at each other with clubs and it was vicious..."

These messages are all consistent. They speak of restoring law and order, rejecting hatred and bigotry and nationally uniting against what is becoming a scourge of political violence. It could get worse from here. Much worse. And through it all, the only way it will stop is when those resorting to violence — all sides — lay down their arms.

The issue of what to do with Confederate statues can be dealt with at the local, state and federal levels depending on where they are located by institutions that we all can participate in. That is the proper venue for resolving these disputes, not violence.

Trump, like King, was intoning emphatically against political violence in all of its forms, working within the framework of our political institutions to achieve change and standing up for the civil society.

What are you standing for?

Robert Romano is the Vice President of Public Policy of Americans for Limited Government.

Only 58 percent?

By Printus LeBlanc

College is supposed to prepare young people for the world. Students are supposed to gain knowledge and learn skills that prepare them for a career, while challenging their minds. Somewhere along the line that changed. Colleges have become indoctrination factories reminiscent of the Soviet Union, and this is influencing the IDEA of college. In fact, a recent Pew poll shows "58 percent of Republicans and Republican-leaning independents say colleges and universities have a negative effect on the way things are going in the country." What caused the change?

On May 17, 1954, the Supreme Court of the United States issued a ruling that is being ignored by many colleges and universities today. Brown v. Board of Education ended the repugnant idea of separate but equal, codified in the SCOTUS case Plessy v. Ferguson in 1896. Simply put, the decision ended racial

segregation by stating segregation is discrimination by race. If this case happened over 60 years ago, why are universities still pushing segregation?

Some universities are now offering segregated housing such as California State University of Los Angeles. The university announced the policy in 2016 to much fanfare. The education watchdog group The College Fix approached the university about the segregation. Cal State LA spokesman Robert Lopez responded via email stating the dormitory, "focuses on academic excellence and learning experiences that are inclusive and non-discriminatory." Yes, an institution of "higher learning" used the words "inclusive and non-discriminatory" when describing segregated housing.

It doesn't end there. According to the New York Times, Harvard University held an African-American only commencement this year for the first time. Once again, a college professes to pursue diversity and inclusivity while practicing the exact opposite. You spend your life teaching your child race doesn't matter, and when your child gets to college they are told the opposite. Somewhere Clinton family mentor and noted segregationists J. William Fulbright is smiling because he is getting what he wanted.

Not only is segregation making a comeback on college campuses, diversity of thought is not allowed on campus at all. Two different studies show a disturbing pattern of discrimination based upon political leanings.

Yoel Inbar and Joris Lammers conducted a study titled "Political Diversity in Social and Personality Psychology." Amongst the findings 25 percent of those surveyed with liberal leanings said they would discriminate against conservatives in grant reviews. One third would discriminate in hiring practices against conservatives.

George Yancy conducted a survey and published by Baylor University titled "Compromising Scholarship, Religious and Political Bias in American Higher Education". The survey found an astounding 30 percent of academics surveyed would be less likely to hire someone if they knew the person was republican. Students depend on the intellectual honesty of professors and professionals for grades and recommendations. How can students trust a college if those running the college have an open disdain for anyone not like them politically?

If you haven't noticed, college campuses seem to be where the heckler's veto became the rioter's veto. It seems every time a conservative group on a college campus wants to have a speaker show up, riots follow. When Milo Yiannopoulos went to speak at UC Berkeley, the capital of the "free speech" movement in the 1960s, he was met with riots from the group Antifa. Antifa is a violent fascist communist group that believes anyone that does not believe what they believe should be attacked, sometimes verbally but most often physically.

This is not a lone incident. Whenever any "conservative" speaker is invited to a college campus, college administrators often use "security" as a reason to disinvite the speaker. Ben Shapiro has had multiple speaking engagements cancelled or interrupted by rioters that disagree him. The question should then be asked, what type of environment is being fostered at a university when a small Jewish man scares the administration into canceling an event?

Not only do these campus groups use the rioter's veto, they use it with impunity. You would be hard pressed to find an instance when a rioter at a campus university faced serious disciplinary actions for their criminal behavior.

The question shouldn't be why republicans do not trust colleges and universities. The question should be, what have colleges and universities done to lose the trust of republicans. They segregate students, ignore the constitution, and don't allow different points of view. After looking at the evidence, frankly, it is surprising only 58 percent of republicans say colleges have a negative effect.

Printus LeBlanc is a contributing reporter for Americans for Limited Government.

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## Big labor fights for big government

By Richard McCarty

The California legislature is currently considering a bill to make it nearly impossible for most county governments to hire companies and nonprofits to deliver public services. The bill, AB 1250, was introduced by a former Service Employees International Union (SEIU) boss, and SEIU is one of its chief proponents.

Why does SEIU care about the manner in which local governments deliver services to their residents? Because it has thousands of members who work for county governments, and SEIU would like to keep them and their dues money.

The bill requires that contracts save money, which sounds reasonable enough. But then the bill stacks the deck against contractors by adding unnecessary costs to contracts. County governments would be required to perform cost-benefit analyses, conduct environmental reviews, provide orientation to the employees of contractors, and perform annual audits. The legislation would also mandate that contracts must not displace any current government employees or even cause them to lose hours; and it would make counties liable for contractors' labor law violations. So, you see why it would be so difficult for counties to contract out – and these are just some of the bill's provisions.

Get the full story [here](#).

Richard McCarty is the Director of Research at Americans for Limited Government Foundation

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ALG Editor's Note: In the following feature from CBS News, Julian Quinones and Arijeta Lajka travel to Iceland and reveal the disgusting way the nation is dealing with children with Down syndrome.

CBS News: Iceland aborts almost 100 percent of at-risk children for Down syndrome, U.S. aborts 67 percent.

By Julian Quinones and Arijeta Lajka

With the rise of prenatal screening tests across Europe and the United States, the number of babies born with Down syndrome has significantly decreased, but few countries have come as close to eradicating Down syndrome births as Iceland.

Since prenatal screening tests were introduced in Iceland in the early 2000s, the vast majority of



women -- close to 100 percent -- who received a positive test for Down syndrome terminated their pregnancy.

While the tests are optional, the government states that all expectant mothers must be informed about availability of screening tests, which reveal the likelihood of a child being born with Down syndrome. Around 80 to 85 percent of pregnant women choose to take the prenatal screening test, according to Landspítali University Hospital in Reykjavik.

"CBSN: On Assignment" headed to Iceland with CBS News correspondent Elaine Quijano to investigate what's factoring into the high termination rates.

Using an ultrasound, blood test and the mother's age, the test, called the Combination Test, determines whether the fetus will have a chromosome abnormality, the most common of which results in Down syndrome. Children born with this genetic disorder have distinctive facial issues and a range of developmental issues. Many people born with Down syndrome can live full, healthy lives, with an average lifespan of around 60 years.

Other countries aren't lagging too far behind in Down syndrome termination rates. According to the most recent data available, the United States has an estimated termination rate for Down syndrome of 67 percent (1995-2011); in France it's 77 percent (2015); and Denmark, 98 percent (2015). The law in Iceland permits abortion after 16 weeks if the fetus has a deformity -- and Down syndrome is included in this category.

Get the full heartbreaking story here.

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To: Shulkin, David J., MD  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Cc:  
Bcc:  
Subject: [EXTERNAL] Your TV Comments on Racism  
Date: Thu Aug 17 2017 09:34:05 CDT  
Attachments:

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David,  
Thank you your very poignant words concerning racial and religious violence in the aftermath of Charlottesville.  
I recall my parents describing Nazi Germany and the unmentionable atrocities they inflicted on Jews there and the loss of our own family members in the Camps. Seeing the white supremacists marching and rioting was absolutely reminiscent of those dark days of Nazi Germany and to think the unimaginable that those behaviors were taking place here in our country. As a Jewish American, I, like you, abhor these acts against any and all minorities and disadvantaged peoples. And your words were right on track, spoken eloquently, and done with absolute finesse in what I can imagine is a difficult environment there.  
I hope you "hang in there" David. We have your back - as best we can.  
The very best to you,

(b) (6)  
Sent from my iPhone  
(b) (6), M.D.  
(210) 323-(b) (6)

On Aug 9, 2017, at 3:00 PM, (b) (6) @hotmail.com> wrote:

David,

Saw the recent article re introduction of telemedicine throughout the VA system. Thought I'd share my experience with introducing telemedicine into a health care system as I did so in Bethel, Alaska, with the Native Healthcare System at Yukon-Kuskokwim Health Corporation in the late 1990s and in Latin American medical humanitarian outreach projects, particularly in Suriname, when I was Command Surgeon at US Army South (2005-2012).

The challenge in both places for me was getting the provider community to accept the technology as a valid way to practice medicine. This was and is similar to EMR acceptance and use of AEDs - with emphasis on automated (hands off) - in everyday medical practice. Hopefully this kind of provider behavior does not obstruct your telemedicine efforts and likely has already been addressed within the VA, though it took us/me more time than desired and expected to get telemedicine to improve patient access to our systems (those mentioned).

Being in an internal medicine/pediatric practice in Colorado Springs running urgent care, I have had the opportunity to see some VA patients. You may be aware that the post acute care of these VA patients, "merging" back into the VA here, has frequently been difficult regarding obtaining follow up in a timely fashion. The VA clinic here is new and diverse, as you know, however, access is perceived by patients

(and even experienced by me) to be cumbersome and bureaucratic (aka slow). Two and a half years ago, the western region VA recruiter sought me out to compete for the position of "medical director" (different title under VA Denver) for the Colorado Springs clinic, which encompasses all of southern Colorado, and help address the access issues they were facing. It was at the same time that I was asked by the executive recruitment team at VA headquarters to apply for the SES level nationwide MCD recruitments (3). The local recruitment ended with a great effort by the regional recruiter but without progress because VA Denver leadership was adamant (per the recruiter) that I had to be family medicine residency trained and BC, irrespective of my clinical and leadership experience in and out of the military. On the national MCD level, I was successfully interviewed, credentialed/privileged by the VA credentials office, put on a Best Qualified list, and set up for potential placement through the VISN Director process. Placement and offer did not come to fore as I later learned from the USA Jobs website. And with the hiring freeze, filling MCD and other physician leadership positions is likely a non starter at this juncture. All this is by way of saying that I admire with your superb work to improve access for Veterans and wish I were able to help you (and your predecessor) to do so.

Hope this finds all well there.

Best,

(b) (6)

(b) (6), M.D., M.P.H.&T.M.

Colonel, US Army (Retired)

Tel: (210) 323-(b) (6) (personal cell)

(719) 488-(b) (6) (home phone)

(210) 251-(b) (6) (wife's cell)

Emails: (b) (6)@hotmail.com; (b) (6)@yahoo.com



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From: Coffey, Georgia </o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b) (5)>  
To: Ulyot, John </o=va/ou=exchange  
administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
</o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)>  
Cc: (b) (6) (VACO) </o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b) (5)> (b) (6)  
</o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)> Wagner,  
John (Wolf) </o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> (b) (6)  
(VA) </o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> Wright,  
Vivieca (Simpson) </o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b) (5)> Blackburn, Scott R.  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> Shulkin, David  
J., MD </o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> Shelby, Peter  
J. </o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Hutton, James </o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Bcc:  
Subject: RE: Message on Charlottesville from Chief Diversity Officer  
Date: Fri Aug 18 2017 16:32:47 CDT  
Attachments: image001.jpg  
image002.jpg  
image003.png  
image004.jpg

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John, thank you for the response and I'd be happy to speak with you further about this, but in the interest of time, I offer the following. It is very important that I reference the hate groups specifically so there is no confusion or equivocation in my message. In fact, other agencies have made such specific references in their statements, and I would want VA to be in the vanguard of this activity. More importantly, many of our VA employees have stressed how important it is to them to hear this from their leadership, and have told me how appreciative they are when they hear it from me. I will gladly share examples of these messages with you if you are interested. Finally, while I appreciate your suggested edits, I fear it dilutes my message and fails to convey the sense of condemnation that I hope we all feel. So here is my preferred response, removing reference to the Secretary and Assistant Secretary out of respect for what I am sensing is your preference:

#### MESSAGE FROM VA'S CHIEF DIVERSITY OFFICER

This past week, Americans were shocked by horrific events in Charlottesville, Virginia that were an assault on our Nation's defining values of diversity and inclusion. The repugnant display of hate and bigotry by white supremacists, neo-Nazis, and the Ku Klux Klan do not represent America, but serve as a tragic reminder that our work in civil rights and inclusion is not finished. I proudly join the growing chorus of universal condemnation of these misguided acts of intolerance by a marginalized few.

As VA's Chief Diversity Officer, I want to assure our employees that we in VA unequivocally reject and condemn the actions of these individuals and stand strong in our commitment to equal opportunity, diversity, and full inclusion for all in VA and beyond. To that point, I ask each of you to promote and model the principles and protections contained in the Secretary's recently issued Equal Employment Opportunity, Diversity and Inclusion, No FEAR, and Whistleblower Rights and Protection Policy Statement available at [https://www.diversity.va.gov/policy/files/EEO\\_Policy\\_Statement.pdf](https://www.diversity.va.gov/policy/files/EEO_Policy_Statement.pdf). Please join us in our unwavering commitment to equity, diversity and inclusion in service to our Nation's Veterans. Thank you.

Georgia Coffey

John, I remain available to discuss this with you but I hope this can proceed in a timely fashion as our employees are anxiously waiting for such a communication.

Respectfully,

Georgia Coffey

Deputy Assistant Secretary for Diversity and Inclusion

U.S. Department of Veterans Affairs

202-461-4131

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<https://survey.htm.va.gov/Perseus/se/7FDA9EA774D03B42>.

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From: Ulyot, John  
Sent: Friday, August 18, 2017 5:12 PM  
To: Coffey, Georgia; (b) (6)

Cc: (b) (6) (VACO); (b) (6); Wagner, John (Wolf); (b) (6) (VA); Wright, Vivieca (Simpson); Blackburn, Scott R.; Shulkin, David J., MD; Shelby, Peter J.; Hutton, James  
Subject: Re: Message on Charlottesville from Chief Diversity Officer

Thanks Georgia — I spoke with the Secretary and he said we should all feel free to share our own personal views on the recent events on social media and other outlets, as he did (to a national audience) on Wednesday where he emphasized that he was giving his own personal views, rather than an official view of the Department.

So once again, we can all share our personal views on individual social media and elsewhere, but you're absolutely right that from the Department, it's entirely appropriate to remind employees of our strong commitment to EEO and diversity, so why don't we say the following, taken from your statement:

#### MESSAGE FROM VA'S CHIEF DIVERSITY OFFICER

As VA's Chief Diversity Officer, I want to assure our employees that we in VA stand strong in our commitment to equal opportunity, diversity, and full inclusion for all in VA and beyond. To that point, I ask each of you to promote and model the principles and protections contained in the Secretary's recently issued Equal Employment Opportunity, Diversity and Inclusion, No FEAR, and Whistleblower Rights and Protection Policy Statement available at [https://www.diversity.va.gov/policy/files/EEO\\_Policy\\_Statement.pdf](https://www.diversity.va.gov/policy/files/EEO_Policy_Statement.pdf). Please join us in our unwavering commitment to equality, diversity and inclusion in service to our Nation's Veterans. Thank you.

Thanks very much Georgia — it's always a good idea to emphasize our commitment in this area.

All the best,

John U.

John Ulliyot

Assistant Secretary for Public and Intergovernmental Affairs

U.S. Department of Veterans Affairs

202-461-7500 office

[john.ullyot@va.gov](mailto:john.ullyot@va.gov)



From: "Coffey, Georgia" <Georgia.Coffey@va.gov>  
Date: Friday, August 18, 2017 at 3:16 PM  
To: "(b) (6)" <[REDACTED]@va.gov>  
Cc: "(b) (6)" (VACO) <[REDACTED]@va.gov>, "(b) (6)" <[REDACTED]@va.gov>, Wolf Wagner <John.Wolf.Wagner@va.gov>, "(b) (6)" (VA) <[REDACTED]@va.gov>, "Wright, Vivieca (Simpson)" <Vivieca.Wright@va.gov>, Department of Veterans Affairs Department of Veterans Affairs <john.ullyot@va.gov>, "Blackburn, Scott R." <Scott.Blackburn@va.gov>, "Shulkin, David J., MD" <David.Shulkin@va.gov>, "Shelby, Peter J." <Peter.Shelby@va.gov>  
Subject: RE: Message on Charlottesville from Chief Diversity Officer

This is very unfortunate. Other agencies have already posted such messages to their workforce (Dept of Education for one). My role as Chief Diversity Officer is to advise the Secretary and provide policy guidance on all matters related to EEO, diversity and inclusion that affect the VA. This national issue, clearly impacts the VA as evidenced by the numerous inquiries and concerns I've received on this. I respect the Secretary's decision if he chooses not to issue the message we drafted for his consideration. However, the message below is mine and consistent with my responsibility as the Chief Diversity Officer of VA to assure our employees of our commitment to EEO and diversity in accordance with law and VA policy. I look forward to speaking with our leadership about this.

Georgia Coffey

Deputy Assistant Secretary for Diversity and Inclusion

U.S. Department of Veterans Affairs

202-461-4131

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<https://survey.htm.va.gov/Perseus/se/7FDA9EA774D03B42>.

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From: "(b) (6)" <[REDACTED]>  
Sent: Friday, August 18, 2017 3:06 PM

To: Coffey, Georgia  
Cc: (b) (6) (VACO); (b) (6) Wagner, John (Wolf); (b) (6) (VA)  
Subject: FW: Message on Charlottesville from Chief Diversity Officer  
Importance: High

Georgia,

OPIA Assistant Secretary John Ulliyot does not want to post the message, as the Secretary previously made statements in the news media on this topic earlier this week. Please see the below message from John "Wolf" Wagner, OPIA Principal Deputy Assistant Secretary. If you have questions, please feel free to reach out to Wolf or John Ulliyot.

Thanks.

(b) (6)

From: Wagner, John (Wolf)  
Sent: Friday, August 18, 2017 2:43 PM  
To: (b) (6)  
Cc: Hutton, James; (b) (6) (VA); Ulliyot, John  
Subject: Re: Message on Charlottesville from Chief Diversity Officer  
Importance: High

(b) (6)

Just spoke with John. We're not going to post anything on this. The SecVA spoke at length on this this week and there are numerous articles in the press regarding his remarks.

Thanks!

John 'Wolf' Wagner  
Principal Deputy Assistant Secretary  
Public and Intergovernmental Affairs  
U.S. Department of Veterans Affairs

O: 202-461-7500

john.wolf.wagner@va.gov

From: "(b) (6)" <[REDACTED]@va.gov>  
Date: Friday, August 18, 2017 at 1:23 PM  
To: Department of Veterans Affairs Department of Veterans Affairs <john.wolf.wagner@va.gov>  
Cc: "Hutton, James" <James.Hutton@va.gov>, "(b) (6)" (VA) <[REDACTED]@va.gov>  
Subject: Message on Charlottesville from Chief Diversity Officer

Wolf,

Please see below for the message that Georgia Coffey, VA's Chief Diversity Officer, would like to post to the internal blog, as well as HeyVA and VACO Daily News. As you can see in the email string below, she also is seeking approval from the Chief of Staff on this.

Ann

From: Coffey, Georgia  
Sent: Friday, August 18, 2017 11:53 AM  
To: Wright, Vivieca (Simpson)  
Cc: "(b) (6)" <[REDACTED]>, "(b) (6)" (VACO); Ulliyot, John; "(b) (6)" <[REDACTED]>  
Shelby, Peter J.; "(b) (6)" <[REDACTED]>  
Subject: FW: VACO Daily News/HEY VAs  
Importance: High

Vivieca,

I understand you are out of the office today however I have been advised to reach out to you directly on this time-sensitive matter. We are seeking your approval to post the message below on Hey VA and other VA news outlets to address the recent events in Charlottesville. We have the ASHRA's consent and are simultaneously clearing this with OPIA. We have also sent the SecVA a draft all-employee message in VAIQ for his consideration and personal dissemination. As im sure you'll understand, we believe it is important for VA to issue a message to our employees denouncing the acts of bigotry and reaffirming our commitment to equity, diversity, and inclusion in VA. Several employees have expressed this to me personally. I am respectfully requesting your expedited approval of the message



below for issuance soonest. Thank you in advance.

Georgia Coffey

Deputy Assistant Secretary for Diversity and Inclusion

U.S. Department of Veterans Affairs

202-461-4131

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From: Coffey, Georgia

Sent: Friday, August 18, 2017 10:44 AM

To: (b) (6)

Cc: (b) (6); Shelby, Peter J.; (b) (6)

Subject: RE: VACO Daily News/HEY VAs

(b) (6) if it's not too late, the Assistant Secretary for HRA, Peter Shelby, would like the language in red below to be added to the 1st paragraph of the VA-wide Broadcast Message. Please advise when this message will go out> Thank you in advance.

#### MESSAGE FROM VA'S CHIEF DIVERSITY OFFICER

This past week, Americans were shocked by horrific events in Charlottesville, Virginia that were an assault on our Nation's defining values of diversity and inclusion. The repugnant display of hate and bigotry by white supremacists, neo-Nazis, and the Ku Klux Klan do not represent America, but serve as a tragic reminder that our work in civil rights and inclusion is not finished. The Secretary of Veterans Affairs (VA), the Assistant Secretary for Human Resources and Administration, and I join the growing chorus of universal condemnation of these misguided acts of intolerance by a marginalized few.

As VA's Chief Diversity Officer, I want to assure our employees that we in VA unequivocally reject and

condemn the actions of these individuals and stand strong in our commitment to equal opportunity, diversity, and full inclusion for all in VA and beyond. To that point, I ask each of you to promote and model the principles and protections contained in the Secretary's recently issued Equal Employment Opportunity, Diversity and Inclusion, No FEAR, and Whistleblower Rights and Protection Policy Statement available at [https://www.diversity.va.gov/policy/files/EEO\\_Policy\\_Statement.pdf](https://www.diversity.va.gov/policy/files/EEO_Policy_Statement.pdf). Please join us in our unwavering commitment to equity, diversity and inclusion in service to our Nation's Veterans. Thank you.

Georgia Coffey

Georgia Coffey

Deputy Assistant Secretary for Diversity and Inclusion

U.S. Department of Veterans Affairs

202-461-4131

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Please provide us feedback on our services:

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From: (b) (6)  
Sent: Thursday, August 17, 2017 3:28 PM  
To: (b) (6)  
Cc: Coffey, Georgia; (b) (6)  
Subject: RE: VACO Daily News/HEY VAs

(b) (6)

Here is Georgia's message (below) and photo (attached). I will be out of the office for the next week beginning this afternoon so your contact if needed will be (b) (6) (copied).

## MESSAGE FROM VA'S CHIEF DIVERSITY OFFICER

This past week, Americans were shocked by horrific events in Charlottesville, Virginia that were an assault on our Nation's defining values of diversity and inclusion. The repugnant display of hate and bigotry by white supremacists, neo-Nazis, and the Ku Klux Klan do not represent America, but serve as a tragic reminder that our work in civil rights and inclusion is not finished. The Secretary of Veterans Affairs (VA) and I join the growing chorus of universal condemnation of these misguided acts of intolerance by a marginalized few.

As VA's Chief Diversity Officer, I want to assure our employees that we in VA unequivocally reject and condemn the actions of these individuals and stand strong in our commitment to equal opportunity, diversity, and full inclusion for all in VA and beyond. To that point, I ask each of you to promote and model the principles and protections contained in the Secretary's recently issued Equal Employment Opportunity, Diversity and Inclusion, No FEAR, and Whistleblower Rights and Protection Policy Statement available at [https://www.diversity.va.gov/policy/files/EEO\\_Policy\\_Statement.pdf](https://www.diversity.va.gov/policy/files/EEO_Policy_Statement.pdf). Please join us in our unwavering commitment to equity, diversity and inclusion in service to our Nation's Veterans. Thank you.

Georgia Coffey

Thank you,

(b) (6)  
Office of Diversity & Inclusion  
U.S. Department of Veterans Affairs  
(202) 461-(b) (6)  
<https://www.diversity.va.gov>

This email and any attachments are intended only for the use of the addressee(s) named herein and may contain privileged and/or confidential information. If you are not the intended recipient of this email, you are hereby notified that any dissemination, distribution or copying of this email, and any attachments thereto, is strictly prohibited. If you have received this email in error, please notify me via return email and via telephone at (202) 461-4007 and permanently delete the original and any copy of any email and any printout thereof.

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From: (b) (6)  
Sent: Thursday, August 17, 2017 11:23 AM  
To: (b) (6)  
Subject: RE: VACO Daily News/HEY VAs



(b) (6)

I'm sorry I'm just getting back to you. I just got in from appointments.

We can get this on VACO News and our national HEY VAs, and the word limit for that is 200 words max.

I usually send them out a week ahead and normally on Thursdays. However, as this is such a critical issue, I can hold on those for a bit, if you think the remarks could be submitted before end of business today.

Also, if you have a good photo we can use -- of Georgia or something diversity-related, even a graphic (approx. 730 wide by 370 in height) -- I can take her remarks and get them on the blog (formerly MyVA, but now named VA NEWS <https://myva.va.gov/blog>), I would like to see it in our Top Stories on there as well.

Thanks!

(b) (6)

Public Affairs Specialist

Office of Public & Intergovernmental Affairs

(b) (6) @va.gov

Follow me on VA Pulse!

Don't miss out – check out the latest VA employee news today on MyVA NEWS.

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Owner: Coffey, Georgia </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)  
Filename: image001.jpg  
Last Modified: Fri Aug 18 16:32:47 CDT 2017

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image001

for Print

Item: 70

Attachme

of 4)



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Filename: image002.jpg  
Last Modified: Fri Aug 18 16:32:47 CDT 2017

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image002.jpg for Printed Item: 70 ( Attachment 2 of 4)

**VIA**  
AMERICAN  
OVERSIGHT



U.S. Department  
of Veterans Affairs  
VA-17-0334-A-00001287

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Owner: Coffey, Georgia </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)  
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Last Modified: Fri Aug 18 16:32:47 CDT 2017

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image003.png for Printed Item: 70 ( Attachment 3 of 4)

**VIA**  
AMERICAN  
OVERSIGHT



U.S. Department  
of Veterans Affairs

VA-17-0334-A-00001239

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Owner: Coffey, Georgia </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)  
Filename: image004.jpg  
Last Modified: Fri Aug 18 16:32:47 CDT 2017

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image004

for Print

Item: 70

Attachme

of 4)

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From: Ulyot, John </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>

To: Coffey, Georgia </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5) (b) (6)>  
</o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)>

Cc: (b) (6) (VACO) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5) (b) (6)>  
</o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5) (b) (6)> Wagner, John (Wolf) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5) (b) (6)>  
(VA) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> Wright, Vivieca (Simpson) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)> Blackburn, Scott R. </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> Shulkin, David J., MD </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> Shelby, Peter J. </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> >;  
Hutton, James </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> >

Bcc:

Subject: Re: Message on Charlottesville from Chief Diversity Officer

Date: Fri Aug 18 2017 16:11:44 CDT

Attachments: 0529F96F-F2A4-4EBE-814B-72709E512B9B[1].jpg  
image001.jpg  
image003.png  
image004.jpg

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Thanks Georgia — I spoke with the Secretary and he said we should all feel free to share our own personal views on the recent events on social media and other outlets, as he did (to a national audience) on Wednesday where he emphasized that he was giving his own personal views, rather than an official view of the Department.

So once again, we can all share our personal views on individual social media and elsewhere, but you're absolutely right that from the Department, it's entirely appropriate to remind employees of our strong commitment to EEO and diversity, so why don't we say the following, taken from your statement:

#### MESSAGE FROM VA'S CHIEF DIVERSITY OFFICER

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Thanks very much Georgia — it's always a good idea to emphasize our commitment in this area.

All the best,

John U.

John Ulyot  
Assistant Secretary for Public and Intergovernmental Affairs  
U.S. Department of Veterans Affairs  
202-461-7500 office  
john.ullyot@va.gov

From: "Coffey, Georgia" <Georgia.Coffey@va.gov>  
Date: Friday, August 18, 2017 at 3:16 PM  
To: (b) (6) @va.gov  
Cc: (b) (6) (VACO) (b) (6) @va.gov, (b) (6) @va.gov, Wolf Wagner <John.Wolf.Wagner@va.gov>, (b) (6) (VA) (b) (6) @va.gov, "Wright, Vivieca (Simpson)" <Vivieca.Wright@va.gov>, Department of Veterans Affairs Department of Veterans Affairs <john.ullyot@va.gov>, "Blackburn, Scott R." <Scott.Blackburn@va.gov>, "Shulkin, David J., MD" <David.Shulkin@va.gov>, "Shelby, Peter J." <Peter.Shelby@va.gov>  
Subject: RE: Message on Charlottesville from Chief Diversity Officer

This is very unfortunate. Other agencies have already posted such messages to their workforce (Dept of Education for one). My role as Chief Diversity Officer is to advise the Secretary and provide policy guidance on all matters related to EEO, diversity and inclusion that affect the VA. This national issue, clearly impacts the VA as evidenced by the numerous inquiries and concerns I've received on this. I respect the Secretary's decision if he chooses not to issue the message we drafted for his consideration. However, the message below is mine and consistent with my responsibility as the Chief Diversity Officer of VA to assure our employees of our commitment to EEO and diversity in accordance with law and VA policy. I look forward to speaking with our leadership about this.

Georgia Coffey

Deputy Assistant Secretary for Diversity and Inclusion

U.S. Department of Veterans Affairs

202-461-4131

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From: (b) (6)  
Sent: Friday, August 18, 2017 3:06 PM  
To: Coffey, Georgia  
Cc: (b) (6) (VACO); (b) (6); Wagner, John (Wolf); (b) (6) (VA)  
Subject: FW: Message on Charlottesville from Chief Diversity Officer  
Importance: High

Georgia,

OPIA Assistant Secretary John Ulyot does not want to post the message, as the Secretary previously made statements in the news media on this topic earlier this week. Please see the below message from John "Wolf" Wagner, OPIA Principal Deputy Assistant Secretary. If you have questions, please feel free to reach out to Wolf or John Ulyot.

Thanks.

(b) (6)

From: Wagner, John (Wolf)  
Sent: Friday, August 18, 2017 2:43 PM  
To: (b) (6)  
Cc: Hutton, James; (b) (6) (VA); Ulyot, John  
Subject: Re: Message on Charlottesville from Chief Diversity Officer  
Importance: High

(b) (6)

Just spoke with John. We're not going to post anything on this. The SecVA spoke at length on this this week and there are numerous articles in the press regarding his remarks.

Thanks!

John 'Wolf' Wagner  
Principal Deputy Assistant Secretary  
Public and Intergovernmental Affairs  
U.S. Department of Veterans Affairs  
O: 202-461-7500  
john.wolf.wagner@va.gov

From: "(b) (6)"@va.gov  
Date: Friday, August 18, 2017 at 1:23 PM  
To: Department of Veterans Affairs Department of Veterans Affairs <john.wolf.wagner@va.gov>  
Cc: "Hutton, James" <James.Hutton@va.gov>, "(b) (6)" (VA)" <(b) (6)"@va.gov>  
Subject: Message on Charlottesville from Chief Diversity Officer

Wolf,

Please see below for the message that Georgia Coffey, VA's Chief Diversity Officer, would like to post to the internal blog, as well as HeyVA and VACO Daily News. As you can see in the email string below, she also is seeking approval from the Chief of Staff on this.

(b) (6)

From: Coffey, Georgia  
Sent: Friday, August 18, 2017 11:53 AM  
To: Wright, Vivieca (Simpson)  
Cc: "(b) (6)" Ulliyot, John; "(b) (6)"  
Shelby, Peter J.; "(b) (6)"  
Subject: FW: VACO Daily News/HEY VAs  
Importance: High

Vivieca,

I understand you are out of the office today however I have been advised to reach out to you directly on this time-sensitive matter. We are seeking your approval to post the message below on Hey VA and other VA news outlets to address the recent events in Charlottesville. We have the ASHRA's consent and are simultaneously clearing this with OPIA. We have also sent the SecVA a draft all-employee message in VAIQ for his consideration and personal dissemination. As im sure you'll understand, we believe it is important for VA to issue a message to our employees denouncing the acts of bigotry and reaffirming our commitment to equity, diversity, and inclusion in VA. Several employees have expressed this to me personally. I am respectfully requesting your expedited approval of the message below for issuance soonest. Thank you in advance.

Georgia Coffey

Deputy Assistant Secretary for Diversity and Inclusion

U.S. Department of Veterans Affairs

202-461-4131

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Please provide us feedback on our services:

<https://survey.htm.va.gov/Perseus/se/7FDA9EA774D03B42>.

VA Core Values: Integrity Commitment Advocacy Respect Excellence

VA Core Characteristics: Trustworthy | Accessible | Quality | Innovative | Agile | Integrated

From: Coffey, Georgia

Sent: Friday, August 18, 2017 10:44 AM

To: (b) (6)

Cc: (b) (6) Shelby, Peter J.; (b) (6)

Subject: RE: VACO Daily News/HEY VAs

(b) (6) if it's not too late, the Assistant Secretary for HRA, Peter Shelby, would like the language in red below to be added to the 1st paragraph of the VA-wide Broadcast Message. Please advise when this message will go out> Thank you in advance.

MESSAGE FROM VA'S CHIEF DIVERSITY OFFICER



This past week, Americans were shocked by horrific events in Charlottesville, Virginia that were an assault on our Nation's defining values of diversity and inclusion. The repugnant display of hate and bigotry by white supremacists, neo-Nazis, and the Ku Klux Klan do not represent America, but serve as a tragic reminder that our work in civil rights and inclusion is not finished. The Secretary of Veterans Affairs (VA), the Assistant Secretary for Human Resources and Administration, and I join the growing chorus of universal condemnation of these misguided acts of intolerance by a marginalized few.

As VA's Chief Diversity Officer, I want to assure our employees that we in VA unequivocally reject and condemn the actions of these individuals and stand strong in our commitment to equal opportunity, diversity, and full inclusion for all in VA and beyond. To that point, I ask each of you to promote and model the principles and protections contained in the Secretary's recently issued Equal Employment Opportunity, Diversity and Inclusion, No FEAR, and Whistleblower Rights and Protection Policy Statement available at [https://www.diversity.va.gov/policy/files/EEO\\_Policy\\_Statement.pdf](https://www.diversity.va.gov/policy/files/EEO_Policy_Statement.pdf). Please join us in our unwavering commitment to equity, diversity and inclusion in service to our Nation's Veterans. Thank you.

Georgia Coffey

Georgia Coffey

Deputy Assistant Secretary for Diversity and Inclusion

U.S. Department of Veterans Affairs

202-461-4131

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From: (b) (6)  
Sent: Thursday, August 17, 2017 3:28 PM  
To: (b) (6)  
Cc: Coffey, Georgia; (b) (6)

Subject: RE: VACO Daily News/HEY VAs

(b) (6)

Here is Georgia's message (below) and photo (attached). I will be out of the office for the next week beginning this afternoon so your contact if needed will be (b) (6) (copied).

#### MESSAGE FROM VA'S CHIEF DIVERSITY OFFICER

This past week, Americans were shocked by horrific events in Charlottesville, Virginia that were an assault on our Nation's defining values of diversity and inclusion. The repugnant display of hate and bigotry by white supremacists, neo-Nazis, and the Ku Klux Klan do not represent America, but serve as a tragic reminder that our work in civil rights and inclusion is not finished. The Secretary of Veterans Affairs (VA) and I join the growing chorus of universal condemnation of these misguided acts of intolerance by a marginalized few.

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Georgia Coffey

Thank you,

(b) (6)

Office of Diversity & Inclusion  
U.S. Department of Veterans Affairs  
(202) 461-(b) (6)  
<https://www.diversity.va.gov>

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From: (b) (6)  
Sent: Thursday, August 17, 2017 11:23 AM  
To: (b) (6)  
Subject: RE: VACO Daily News/HEY VAs

(b) (6)

I'm sorry I'm just getting back to you. I just got in from appointments.

We can get this on VACO News and our national HEY VAs, and the word limit for that is 200 words max.

I usually send them out a week ahead and normally on Thursdays. However, as this is such a critical issue, I can hold on those for a bit, if you think the remarks could be submitted before end of business today.

Also, if you have a good photo we can use -- of Georgia or something diversity-related, even a graphic (approx. 730 wide by 370 in height) -- I can take her remarks and get them on the blog (formerly MyVA, but now named VA NEWS <https://myva.va.gov/blog>), I would like to see it in our Top Stories on there as well.

Thanks!

(b) (6)

Public Affairs Specialist

Office of Public & Intergovernmental Affairs

(b) (6) @va.gov

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Owner: Ulliyot, John </o=va/ou=exchange administrative group (fydibohf23spdlt)  
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Last Modified: Fri Aug 18 16:11:44 CDT 2017

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U.S. Department  
of Veterans Affairs

VA-17-0334-A-0000232

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Last Modified: Fri Aug 18 16:11:44 CDT 2017

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image001

for Print

Item: 75

Attachme

of 4)



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Filename: image003.png  
Last Modified: Fri Aug 18 16:11:44 CDT 2017

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image003.png for Printed Item: 75 ( Attachment 3 of 4)

**VIA**  
AMERICAN  
OVERSIGHT



U.S. Department  
of Veterans Affairs  
VA-17-0334-A-0000236

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Last Modified: Fri Aug 18 16:11:44 CDT 2017

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image004

for Print

Item: 75

Attachme

of 4)



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From: Ulliyot, John </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
To: Coffey, Georgia </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)>  
Cc: Blackburn, Scott R. </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> Shulkin, David J., MD </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Bcc:  
Subject: RE: Message on Charlottesville from Chief Diversity Officer  
Date: Fri Aug 18 2017 16:38:45 CDT  
Attachments: image001.jpg  
image002.jpg  
image003.png  
image004.jpg

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(Reduced distribution)

Thanks for your reply Georgia, but SecVA specifically approved that statement in my previous mail for the reasons indicated so that is the one we will go with.

Scott Blackburn said he'd be glad to talk with you on it when he gets back Tuesday.

Thanks again, and enjoy the weekend.

John U.

Sent with Good (www.good.com)

-----Original Message-----

From: Coffey, Georgia  
Sent: Friday, August 18, 2017 05:32 PM Eastern Standard Time  
To: Ulliyot, John; (b) (6)  
Cc: (b) (6) (VACO); (b) (6); Wagner, John (Wolf); (b) (6) (VA); Wright, Vivieca (Simpson); Blackburn, Scott R.; Shulkin, David J., MD; Shelby, Peter J.; Hutton, James  
Subject: RE: Message on Charlottesville from Chief Diversity Officer

John, thank you for the response and I'd be happy to speak with you further about this, but in the interest of time, I offer the following. It is very important that I reference the hate groups specifically so there is no confusion or equivocation in my message. In fact, other agencies have made such specific references in their statements, and I would want VA to be in the vanguard of this activity. More importantly, many of our VA employees have stressed how important it is to them to hear this from their leadership, and have told me how appreciative they are when they hear it from me. I will gladly share examples of these messages with you if you are interested. Finally, while I appreciate your suggested edits, I fear it dilutes my message and fails to convey the sense of condemnation that I hope we all feel. So here is my preferred response, removing reference to the Secretary and Assistant Secretary

respect for what I am sensing is your preference:

## MESSAGE FROM VA'S CHIEF DIVERSITY OFFICER

This past week, Americans were shocked by horrific events in Charlottesville, Virginia that were an assault on our Nation's defining values of diversity and inclusion. The repugnant display of hate and bigotry by white supremacists, neo-Nazis, and the Ku Klux Klan do not represent America, but serve as a tragic reminder that our work in civil rights and inclusion is not finished. I proudly join the growing chorus of universal condemnation of these misguided acts of intolerance by a marginalized few.

As VA's Chief Diversity Officer, I want to assure our employees that we in VA unequivocally reject and condemn the actions of these individuals and stand strong in our commitment to equal opportunity, diversity, and full inclusion for all in VA and beyond. To that point, I ask each of you to promote and model the principles and protections contained in the Secretary's recently issued Equal Employment Opportunity, Diversity and Inclusion, No FEAR, and Whistleblower Rights and Protection Policy Statement available at [https://www.diversity.va.gov/policy/files/EEO\\_Policy\\_Statement.pdf](https://www.diversity.va.gov/policy/files/EEO_Policy_Statement.pdf). Please join us in our unwavering commitment to equity, diversity and inclusion in service to our Nation's Veterans. Thank you.

Georgia Coffey

John, I remain available to discuss this with you but I hope this can proceed in a timely fashion as our employees are anxiously waiting for such a communication.

Respectfully,

Georgia Coffey

Deputy Assistant Secretary for Diversity and Inclusion

U.S. Department of Veterans Affairs

202-461-4131

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VA Core Characteristics: Trustworthy | Accessible | Quality | Innovative | Agile | Integrated

From: Ulliyot, John  
Sent: Friday, August 18, 2017 5:12 PM  
To: Coffey, Georgia; Scholl, Ann  
Cc: (b) (6) (VACO); (b) (6); Wagner, John (Wolf); (b) (6) (VA); Wright, Vivieca (Simpson); Blackburn, Scott R.; Shulkin, David J., MD; Shelby, Peter J.; Hutton, James  
Subject: Re: Message on Charlottesville from Chief Diversity Officer

Thanks Georgia — I spoke with the Secretary and he said we should all feel free to share our own personal views on the recent events on social media and other outlets, as he did (to a national audience) on Wednesday where he emphasized that he was giving his own personal views, rather than an official view of the Department.

So once again, we can all share our personal views on individual social media and elsewhere, but you're absolutely right that from the Department, it's entirely appropriate to remind employees of our strong commitment to EEO and diversity, so why don't we say the following, taken from your statement:

#### MESSAGE FROM VA'S CHIEF DIVERSITY OFFICER

As VA's Chief Diversity Officer, I want to assure our employees that we in VA stand strong in our commitment to equal opportunity, diversity, and full inclusion for all in VA and beyond. To that point, I ask each of you to promote and model the principles and protections contained in the Secretary's recently issued Equal Employment Opportunity, Diversity and Inclusion, No FEAR, and Whistleblower Rights and Protection Policy Statement available at [https://www.diversity.va.gov/policy/files/EEO\\_Policy\\_Statement.pdf](https://www.diversity.va.gov/policy/files/EEO_Policy_Statement.pdf). Please join us in our unwavering commitment to equality, diversity and inclusion in service to our Nation's Veterans. Thank you.

Thanks very much Georgia — it's always a good idea to emphasize our commitment in this area.

All the best,

John U.

John Ullyot

Assistant Secretary for Public and Intergovernmental Affairs

U.S. Department of Veterans Affairs

202-461-7500 office

john.ullyot@va.gov

From: "Coffey, Georgia" (b) (6) @va.gov>  
Date: Friday, August 18, 2017 at 3:16 PM  
To: (b) (6) va.gov>  
Cc: (b) (6) (VACO)" (b) (6) @va.gov, (b) (6) @va.gov, Wolf Wagner <John.Wolf.Wagner@va.gov>, (b) (6) (VA)" (b) (6) @va.gov, "Wright, Vivieca (Simpson)" <Vivieca.Wright@va.gov>, Department of Veterans Affairs Department of Veterans Affairs <john.ullyot@va.gov>, "Blackburn, Scott R." <Scott.Blackburn@va.gov>, "Shulkin, David J., MD" <David.Shulkin@va.gov>, "Shelby, Peter J." <Peter.Shelby@va.gov>  
Subject: RE: Message on Charlottesville from Chief Diversity Officer

This is very unfortunate. Other agencies have already posted such messages to their workforce (Dept of Education for one). My role as Chief Diversity Officer is to advise the Secretary and provide policy guidance on all matters related to EEO, diversity and inclusion that affect the VA. This national issue, clearly impacts the VA as evidenced by the numerous inquiries and concerns I've received on this. I respect the Secretary's decision if he chooses not to issue the message we drafted for his consideration. However, the message below is mine and consistent with my responsibility as the Chief Diversity Officer of VA to assure our employees of our commitment to EEO and diversity in accordance with law and VA policy. I look forward to speaking with our leadership about this.

Georgia Coffey

Deputy Assistant Secretary for Diversity and Inclusion

U.S. Department of Veterans Affairs

202-461-4131

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From: (b) (6)  
Sent: Friday, August 18, 2017 3:06 PM  
To: Coffey, Georgia  
Cc: (b) (6) (VACO); (b) (6); Wagner, John (Wolf); (b) (6) (VA)  
Subject: FW: Message on Charlottesville from Chief Diversity Officer  
Importance: High

Georgia,

OPIA Assistant Secretary John Ulliyot does not want to post the message, as the Secretary previously made statements in the news media on this topic earlier this week. Please see the below message from John "Wolf" Wagner, OPIA Principal Deputy Assistant Secretary. If you have questions, please feel free to reach out to Wolf or John Ulliyot.

Thanks.

(b) (6)

From: Wagner, John (Wolf)  
Sent: Friday, August 18, 2017 2:43 PM  
To: (b) (6)  
Cc: (b) (6) Ulliyot, John  
Subject: Re: Message on Charlottesville from Chief Diversity Officer  
Importance: High

(b) (6)

Just spoke with John. We're not going to post anything on this. The SecVA spoke at length on this this week and there are numerous articles in the press regarding his remarks.

Thanks!

John 'Wolf' Wagner  
Principal Deputy Assistant Secretary  
Public and Intergovernmental Affairs  
U.S. Department of Veterans Affairs  
O: 202-461-7500  
john.wolf.wagner@va.gov

From: (b) (6) @va.gov>  
Date: Friday, August 18, 2017 at 1:23 PM  
To: Department of Veterans Affairs Department of Veterans Affairs <john.wolf.wagner@va.gov>  
Cc: "Hutton, James" <James.Hutton@va.gov>, (b) (6) (VA)" <(b) (6) @va.gov>  
Subject: Message on Charlottesville from Chief Diversity Officer

Wolf,

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(b) (6)

From: Coffey, Georgia  
Sent: Friday, August 18, 2017 11:53 AM  
To: Wright, Vivieca (Simpson)  
Cc: (b) (6) (VACO); Ulliyot, John; (b) (6) (VACO); (b) (6); Shelby, Peter J.; (b) (6)  
Subject: FW: VACO Daily News/HEY VAs  
Importance: High

Vivieca,

I understand you are out of the office today however I have been advised to reach out to you directly on this time-sensitive matter. We are seeking your approval to post the message below on Hey VA and other VA news outlets to address the recent events in Charlottesville. We have the ASHRA's consent and are simultaneously clearing this with OPIA. We have also sent the SecVA a draft all-employee message in VAIQ for his consideration and personal dissemination. As im sure you'll understand, we believe it is important for VA to issue a message to our employees denouncing the acts of bigotry and reaffirming our commitment to equity, diversity, and inclusion in VA. Several employees have expressed this to me personally. I am respectfully requesting your expedited approval of the message below for issuance soonest. Thank you in advance.

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U.S. Department of Veterans Affairs

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From: Coffey, Georgia

Sent: Friday, August 18, 2017 10:44 AM

To: (b) (6)

Cc: (b) (6) Shelby, Peter J.; (b) (6)

Subject: RE: VACO Daily News/HEY VAs

(b) (6) if it's not too late, the Assistant Secretary for HRA, Peter Shelby, would like the language in red below to be added to the 1st paragraph of the VA-wide Broadcast Message. Please advise when this message will go out> Thank you in advance.

MESSAGE FROM VA'S CHIEF DIVERSITY OFFICER

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As VA's Chief Diversity Officer, I want to assure our employees that we in VA unequivocally reject and condemn the actions of these individuals and stand strong in our commitment to equal opportunity, diversity, and full inclusion for all in VA and beyond. To that point, I ask each of you to promote and model the principles and protections contained in the Secretary's recently issued Equal Employment Opportunity, Diversity and Inclusion, No FEAR, and Whistleblower Rights and Protection Policy Statement available at [https://www.diversity.va.gov/policy/files/EEO\\_Policy\\_Statement.pdf](https://www.diversity.va.gov/policy/files/EEO_Policy_Statement.pdf). Please join us in our unwavering commitment to equity, diversity and inclusion in service to our Nation's Veterans. Thank you.

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Deputy Assistant Secretary for Diversity and Inclusion

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From: (b) (6)



Sent: Thursday, August 17, 2017 3:28 PM

To: (b) (6)

Cc: Coffey, Georgia; (b) (6)

Subject: RE: VACO Daily News/HEY VAs

(b) (6)

Here is Georgia's message (below) and photo (attached). I will be out of the office for the next week beginning this afternoon so your contact if needed will be Carolyn Wong (copied).

#### MESSAGE FROM VA'S CHIEF DIVERSITY OFFICER

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Georgia Coffey

Thank you,

(b) (6)

Office of Diversity & Inclusion

U.S. Department of Veterans Affairs

(202) 461-(b) (6)

<https://www.diversity.va.gov>

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From: (b) (6)  
Sent: Thursday, August 17, 2017 11:23 AM  
To: (b) (6)  
Subject: RE: VACO Daily News/HEY VAs

(b) (6)

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Thanks!

(b) (6)

Public Affairs Specialist

Office of Public & Intergovernmental Affairs

(b) (6) @va.gov

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Owner: Ulliyot, John </o=va/ou=exchange administrative group (fydibohf23spdlt)  
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Filename: image001.jpg  
Last Modified: Fri Aug 18 16:38:45 CDT 2017

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image001

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Item: 80

Attachme

of 4)

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Last Modified: Fri Aug 18 16:38:45 CDT 2017

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image002.jpg for Printed Item: 80 ( Attachment 2 of 4)

**VIA**  
AMERICAN  
OVERSIGHT



U.S. Department  
of Veterans Affairs  
VA-17-0334-A-0000223

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image003.png for Printed Item: 80 ( Attachment 3 of 4)

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U.S. Department  
of Veterans Affairs  
VA-17-0334-A-0000225

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Owner: Ulliyot, John </o=va/ou=exchange administrative group (fydibohf23spdlt)  
/cn=recipients/cn=(b) (6), (b) (6)  
Filename: image004.jpg  
Last Modified: Fri Aug 18 16:38:45 CDT 2017

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Item: 80

Attachme

of 4)

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From: (b) (6) @casenetwork.com>  
To: Shulkin, David J., MD  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Cc:  
Bcc:  
Subject: [EXTERNAL] Speaking out  
Date: Thu Aug 17 2017 06:34:28 CDT  
Attachments:

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Hi David,

I follow very closely all the amazing things you are doing for the VA.

I just wanted to thank you as a concerned American and Jew for speaking out yesterday. I know that is not easy for you to do in your position.

(b) (6)

David Shulkin, the secretary of veterans affairs, delivered an emotional statement to reporters on Wednesday at Mr. Trump's private golf club in Bedminster, N.J., where the president is vacationing. Treading carefully without chiding Mr. Trump, Mr. Shulkin said: "Well, I'm speaking out, and I'm giving my personal opinions as an American and as a Jewish American. And for me in particular, I think in learning history, that we know that staying silent on these issues is simply not acceptable."

Paraphrasing famous words from Martin Niemöller, a German pastor and a vocal critic of Adolf Hitler, Mr. Shulkin said, "First, they came for the socialists, and I did not speak out. Then they came for the trade unionists, and I wasn't a trade unionist, so I didn't speak out. Then they came for the Jews. I wasn't a Jew so I didn't speak out. Then they came for me, and there was no one to speak for me."

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From: American Security Today  
<twaitt=americansecuritytoday.com@mail9.atl11.rsgsv.net> on  
behalf of American Security Today  
<(b) (6)@americansecuritytoday.com>  
To: Shulkin, David J., MD  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Cc:  
Bcc:  
Subject: [MARKETING] [EXTERNAL] Twitter Outs Marchers, Duke Robotics, MS-13 Gang  
Sweep, Canon U.S.A., NICE PSAP's, DHS S&T  
Date: Wed Aug 16 2017 06:02:14 CDT  
Attachments:

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August 16, 2017

Twitter Outs People who Marched in Charlottesville (Multi-Video)

A campaign to name & shame people who marched at the violent right-wing rally in Charlottesville has so far prompted two universities to condemn white supremacy & the shaming campaign claimed some innocent casualties... [Read More](#)

Canon U.S.A. in 2017 'ASTORS' Homeland Security Awards

The imageRUNNER ADVANCE platform, a line of multifunction print devices, offers a range of security capabilities that can help facilitate the confidentiality & accessibility of info. Its Universal Login Manager app helps users retrieve sensitive prints once authenticated... [Read More](#)

Duke Robotics - Invest in Keeping Our Troops Safe (Multi-Video)

Duke Robotics has developed TIKAD - the Gun-Toting Drone that can Aim, Fire & Compensate for Recoil, a fully robotic weaponry system that can provide immediate aerial support. Capable of carrying various weapon payloads... [Read More](#)

MS-13 Gang Sweep in OH & IN Nets 13 Arrests (Multi-Video)

15 alleged members & associates of the notoriously violent MS-13 street gang are facing federal charges in OH & IN according to prosecutors. 13 were arrested Tuesday morning with two on the run. If you are a victim or have info... [Read More](#)

NICE Recognizes Emerg Comm PSAP's Finest Award Recipients

Winners of the 2017 PSAPs' Finest Awards, recognizing individual contributions to emergency comms have been announced by NICE, a leading provider of public safety solutions for 9-1-1 centers, which includes 'Innovator of the Year'... [Read More](#)

Trump Signs Order to Speed Infrastructure Construction (Video)

President Donald Trump said Tuesday in a news conference at Trump Tower, that he has signed a new EO intended to make more efficient the federal permitting process for transportation, water & other infrastructure projects without harming the... [Read More](#)

S&T Evaluates Touch-Free Finger Print Scanners (Learn More)

DHS S&T is working with the TSA to evaluate new touch-free ID verification tech that can reduce the time for travelers to pass through security. TSA began a series of proof-of-concept tests for S&T's Biometrics Technology Engine... [Read More](#)

Laredo Border Patrol Updates, Recent Rescues & New Leader

Laredo Sector Border Patrol has selected Michael S. Lata as the newly appointed Patrol Agent in Charge of the Laredo North Border Patrol Station & Laredo BORSTAR agents continue rescue efforts as the temperatures rise... [Read More](#)

ER Partners with StreetWise for Fire & EMS Agencies (Multi-Video)

Emergency Reporting with StreetWise links mobile data produced during a response with data stored in depart's records, to significantly improve accuracy, situational awareness, safety & efficiency during emergency responses... [Read More](#)

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From: (b) (6) @hotmail.com>  
To:  
Cc:  
Bcc:  
Subject: [EXTERNAL] NEJM on Med School Educ/More Voters for Universal Care/Epic Checklist decreases ICU mortality and Central Line Infections  
Date: Wed Aug 16 2017 20:53:15 CDT  
Attachments: NEJMp1706474.pdf  
NEJMp1706528.pdf  
NEJMs1710032.pdf

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Dear Hospital Leaders and Teachers,

This evening's NEJM online has two Perspectives that deal with 'new' teaching methods for medical schools:

1. 'Saying Goodbye to Lectures-in Medical School' deals with the fact that med students today are IT savvy and use to teams so that they can learn basic material on their own outside of lectures in large auditoriums. The perspective discusses the 'active' learning that takes place at Harvard using teams that group learn and quiz each other. Cases are presented that involve the concepts being taught. Instructors are available for questions and explanation. See the first pdf attached above.

2. 'Medical Education in the Era of Alternative Facts' deals with how to teach 'critical thinking' in medical school. The author is concerned that students won't be interested in fact checking articles they read or determining if a scientific method was used in experiments they read about. See the second pdf attached above.

Interestingly, today's WSJ has an article titled 'The Smarter Way to Study' which also emphasizes 'active learning'-quizzing yourself about material learned, asking questions of teachers, getting to the take-home points in lectures, etc. See: <https://www.wsj.com/articles/the-smarter-ways-to-study-1502810531>. Students who are active learners do better grade wise and ACT/SAT wise than passive learners.

A Special Review in the NEJM issue tonight deals with public opinion on what should be done with the ACA by this Congress. The opinions about repeal, reform, and replace are what you would think from Republicans and Democrats; not much change between 2010-2017. But what has changed is that more people want universal health care and fewer people are against universal health care over the years and goings on by Congress. See Figure 1 in the third pdf attached above.

Also noteworthy tonight is a blurb by Becker's... about an Epic report stating that the Epic ICU Checklist led to a reduction in ICU mortality of 28% and reduction in central venous line infections of 85% at one hospital. See:

<http://www.epic.com/epic/post/2999>. I have requested the Epic ICU Checklist from Epic for us.

Be well,

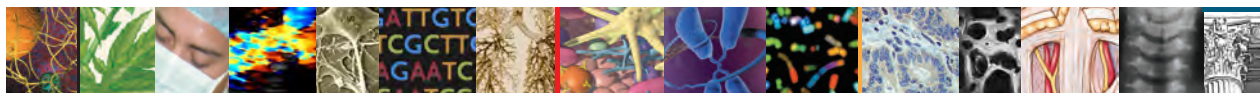
(b) (6), M.D.



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Filename: NEJMp1706474.pdf  
Last Modified: Wed Aug 16 20:53:15 CDT 2017

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# The NEW ENGLAND JOURNAL of MEDICINE

## Perspective

AUGUST 17, 2017

### Saying Goodbye to Lectures in Medical School — Paradigm Shift or Passing Fad?

Richard M. Schwartzstein, M.D., and David H. Roberts, M.D.

“**B**ecome a doctor, no lectures required.”<sup>1</sup> This headline about the University of Vermont’s proposed new approach to medical education generated considerable controversy. Al-

though this proposed change is more drastic than the curriculum reform taking place at other medical schools, the movement away from traditional lecture-based courses has been under way in U.S. medical schools for more than three decades. Transformation began with the introduction of problem-based learning; more recently, lecture-based teaching has increasingly been replaced by team-based learning, interprofessional education, and exercises integrating clinical medicine and basic science. But are the newest proposed changes evidence-based, or are they merely the latest fad in medical education? Are all lectures to be avoided?

Most physicians today readily acknowledge that the biomedical information available exceeds what one person can learn and retain. Questions remain, however, regarding how much content students must learn, whether that learning is best done in traditional classroom settings, and what else is required for medical trainees to become successful lifelong learners and adaptable practitioners. The ubiquitous presence of personal and institutional technology permits rapid access to medical information and enables educators to focus on helping students develop a deeper understanding of human health and disease, problem-solving skills,

and the ability to transfer knowledge learned in one context to another situation.<sup>2</sup> Educators giving a traditional lecture with dozens of content-heavy PowerPoint slides may confuse what they teach with what students learn: the fact that a teacher has presented a piece of information does not mean that students have learned it. In fact, cognitive-load theory suggests that our brains are limited in the amount of information they can process at a time<sup>3</sup>; 60 slides in 45 minutes may seem like an efficient way to teach, but it is unlikely to be an effective way to learn.

Students learning new material may be deceived by the illusion of knowing and the fallacy of understanding.<sup>2</sup> When students hear or read material that is fluent and well presented, it is common for them to believe they have now mastered the content.



**Faculty and Students Interacting in Learning Studios at Harvard Medical School.**

In the “Pathways” curriculum, students focus on the application of concepts to solve clinical problems. Selected lectures remain in most courses to create frameworks for subsequent learning.

When confronted with a problem that requires application of that information, however, they may realize that their understanding is superficial at best.

To promote more thorough understanding and enhance problem-solving skills and self-directed learning — critical skills for a doctor who will be practicing for 30 to 50 years and, in the case of self-directed learning exercises, a new requirement for accreditation established by the Liaison Committee on Medical Education — medical schools have begun emphasizing active learning and team-based activities. Acquisition of information occurs largely outside the classroom: in accordance with principles derived from cognitive science, factual content is presented in study assignments that aren’t overwhelmingly long, and the content is interspersed with questions or problems to ensure that students can assess their level of understanding.

In the classroom, learning can be facilitated by the instructor,

but it must be driven in large part by the student. Case vignettes are important for establishing the relevance of the material. Questions can be posed in a manner that requires retrieval of information, which solidifies memory but also compels students to view information from a new perspective and transfer it to the context of the given case. Instead of posing questions that begin with “what” (e.g., “What are the causes of hypotension?”), instructors can use “how” and “why” questions (e.g., “How do you think about blood pressure control?”; “Why would this patient be hypotensive under these conditions?”). Asking students to compare a new case or example with one they discussed the previous week further facilitates the transfer of knowledge.<sup>3</sup> Questions for which there can be multiple right answers can be the most compelling because they encourage discourse and generation of contrasting hypotheses. Time must be allowed for students to work in groups to


discuss thoughts, test ideas (both theirs and others), and begin to learn how to think like a doctor. These activities require more effort from students than it takes to memorize facts, but they are also more effective for learning and retaining knowledge.<sup>2</sup>

This so-called flipped classroom approach is well suited to students who are members of the millennial generation.<sup>4</sup> These young adults are digital natives — they have grown up with technology and are intimately familiar with it. Raised to be part of teams, they thrive in collaborative environments. They are accustomed to finding information online and learn best from visually appealing content that keeps them engaged and is presented in short segments (such as videos that are less than 10 minutes long). The traditional lecture will quickly lose the attention of many of these students, and an unengaged student is not learning.

The early returns from this approach have been encouraging, particularly in college science courses and in the dozen or so medical schools that are implementing new curricula using these pedagogical methods (see photo). In a randomized, controlled trial comparing an early version of the flipped classroom with traditional problem-based learning tutorials, students found the alternative learning environment to be more engaging and thought-provoking.<sup>5</sup> Students who had performed relatively poorly in prior courses had a statistically significant improvement in their exam scores — possibly because interacting with their peers and sharing their ideas prepared them better. Faculty using a flipped-classroom approach often feel liberated from the tyr-

anny of the requirement to “cover” everything. Since acquisition of information is accomplished by the student outside class, interactions between teachers and students can focus on content that is difficult to understand and on the application of new concepts to real-world problems.

So is the lecture dead? If “lecture” refers to the traditional picture of a professor standing in front of and talking at a large group of students who are passively absorbing information, then yes, we believe medical schools should be largely abandoning that teaching format. But if it describes large-group interactive learning sessions with students who have prepared in advance,

 An audio interview with Dr. Schwartzstein is available at NEJM.org

with frequent questions directed at the audience, time set aside for group discussion, and use of audience-response systems (to poll students on a question to assess for understanding, for example), then we

believe an interactive lecture-style format should remain an option and can be an effective teaching tool.

As we look to the future of medical education, we believe it's important to avoid zealotry with respect to pedagogical approaches, including the insistence that team-based learning methods must adhere to specific criteria or that no deviation from pure problem-based learning is allowed. We can often serve our students best by fusing elements of various methods, such as team-based or case-based learning and interactive large-group learning sessions, rather than feeling obliged to adhere to a particular format. But we must also use evidence-based approaches whenever possible and rigorously evaluate our innovations, acknowledging that important outcomes may include student engagement and problem-solving skills, team dynamics, and the learning environment as much as exam scores.

In our daily lives as clinicians, we aim to create a culture of continuous quality improvement. We should strive to create the same culture in our educational lives.

Disclosure forms provided by the authors are available at NEJM.org.

From the Division of Pulmonary, Critical Care, and Sleep Medicine, Beth Israel Deaconess Medical Center, and Harvard Medical School — both in Boston.

1. Straumsheim C. Become a doctor, no lectures required. *Inside Higher Ed*. September 26, 2016 (<https://www.insidehighered.com/news/2016/09/26/u-vermont-medical-school-get-rid-all-lecture-courses>).
2. Brown PC, Roediger HL III, McDaniel MA. *Make it stick: the science of successful learning*. Cambridge, MA: Harvard University Press, 2014.
3. de Jong T. Cognitive load theory, educational research, and instructional design: some food for thought. *Instr Sci* 2010;38:105-34.
4. Roberts DH, Newman LR, Schwartzstein RM. Twelve tips for facilitating Millennials' learning. *Med Teach* 2012;34:274-8.
5. Krupat E, Richards JB, Sullivan AM, Fleenor TJ Jr, Schwartzstein RM. Assessing the effectiveness of case-based collaborative learning via randomized controlled trial. *Acad Med* 2016;91:723-9.

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## Medical Education in the Era of Alternative Facts

Richard P. Wenzel, M.D.

Students currently entering U.S. medical schools arrive in an era of increasing distrust of large institutions, expanded use of social media for information, a political lexicon in which uncomfortable facts are derided as “fake news” while fabrications masquerade as reality, and the erosion of truth that such trends entail. The challenges for medical education are imminent and formidable. How do we, as teachers, merit the trust of future physicians? How do we pass on to

them science's preeminent legacy of propelling advances in understanding, preventing, and curing illnesses? How do we instill in them a lifelong appreciation for the importance of hypothesis testing, peer review, and critical analysis of research? These questions should prompt an immediate review of the goals and processes of education and the values we need to emphasize in day-to-day interactions with students.

A useful early step in earning the warrants of students is a

transparent review of the history of ideas in medicine. Such a survey would make clear that some ideas have worked, some have failed, and some have turned out to be built on scientific fraud — but that developing and testing hypotheses that might not pan out are essential to the scientific method. New ideas have often been rebuffed strongly by people in authority who had reason to fear challenges to the status quo. Some investigators didn't live long enough to see their novel ideas




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2. Brown PC, Roediger HL III, McDaniel MA. *Make it stick: the science of successful learning*. Cambridge, MA: Harvard University Press, 2014.
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become widely accepted. Those who succeeded, however, evinced not only unyielding perseverance, but also integrity and dedication not for personal gain but for the public good. Renewing a strong curriculum in the history of medicine would thus lay a foundation for a realistic yet hopeful appreciation for the potential, advances, and truths of science.

On the hopeful front, a related and necessary building block for students is the intellectual curiosity to both identify and question those truths. We can let medical students know that whereas throughout their previous schooling they were judged by their answers, in their medical education and their careers they will often be judged predominantly by their questions. We should applaud students for curiosity and inquiry and for showing reasoned doubt about what they read and hear. We can challenge them to pursue reliable information beyond the classroom or ward discussions, as we avoid the pitfalls of trying to transfer all our knowledge to them during our face-to-face time. As William Butler Yeats (probably paraphrasing Plutarch) wrote, “Education is not the filling of a pail but the lighting of a fire.” Providing the spark is our job.

On the realistic front, lest the fire of scientific inquiry be extinguished by setbacks, we also need to acknowledge to students that advances in science are slow and nonlinear and are often made by observing something unusual and unexpected, perhaps unrelated to the original hypothesis. Discovery requires not just curiosity but also a passion for clarity — a goal that requires time to achieve, and time is a fading indulgence in modern medicine. Students need

to understand that opportunity is an intermittent visitor, often arriving in disguise and unannounced. If we fail to recognize and engage her, like a shy guest at a large reception, she moves quietly in another direction. Pursuing such opportunity requires what Pasteur called a “prepared mind.”

Given the sometimes elusive and often provisional nature of scientific truth, we need to emphasize that our books are vastly incomplete and that current concepts represent only a temporary resting place for understanding, continually requiring testing and further analyses. They are not the final word but a brief stop on the path we seek: truth through science. To paraphrase the protagonist of Bertolt Brecht’s *Life of Galileo*, the goal of science is not to open the doors to everlasting wisdom but rather to close the doors to everlasting ignorance.<sup>1</sup> Not all faculty members can model a genuine passion for new knowledge, but those who do should be recruited, selected, and rewarded for their talents. This long-recognized need is even more urgent today.

But such educators will have to make clear to students that science and the pursuit of truth require not just passion, but also critical thinking, which can’t easily fit into a tweet or brief social media post. Describing key values to impart to college students, Kim Benston, president of Haverford College, asserts that “we are unequivocally choosing analytical precision over untested assertion.”<sup>2</sup> Medical school deans can encourage the inculcation of these ideals by colleges and universities that prepare students for medical education. And medical schools themselves can re-

double their commitment to clarity and truth by emphasizing critical thinking. Critical review of the literature, for example, is such an essential skill that I believe it should be taught, practiced, and honed throughout all 4 years of medical school and even formally in postgraduate education.

While encouraging students to question both new information and received dogma, we need to support respect for one another, tolerating disparate views without creating unnecessary polarization. The legacy of our field is now frequently challenged by uncritical acceptance of sound bites, a common but unfortunate pattern of our social fabric. We cannot sit by helplessly — our students and their future patients deserve more.

Clinician-educators will face special challenges in an era characterized by the erosion of our time for reflection, for identifying new syndromes, for social contact with colleagues, and for teaching.<sup>3,4</sup> The pressure to see more and more patients for increasingly brief visits is of concern for clinicians, students, and patients alike.<sup>5</sup> But despite time constraints, it is up to us as teachers and role models to reinforce the highest values of our profession, to examine our curriculum and teaching faculty, and to remind our students of the discipline, the great calling, the passion and mystery, and the elegant adventure that define medicine. Reflecting on the current challenges to our profession, we can have a firm response: There is no alternative to truth. So as medical educators, we need to focus increasingly on the rigorous pathway of reason, guiding our students past the barrage of misleading signals

designed to divert their attention from the course to truth.

Disclosure forms provided by the author are available at NEJM.org.

From the Department of Internal Medicine, Virginia Commonwealth University (VCU) Health, Richmond.

1. Brecht B. Life of Galileo. Scene 9.74.
2. Benston K. Learning in a “post-truth” world. Haverford Magazine. Winter 2017;5 ([http://www.bluetoad.com/article/View\\_From\\_Founders/2744680/394224/article.html](http://www.bluetoad.com/article/View_From_Founders/2744680/394224/article.html)).
3. Wenzel RP, Edmond MB. Academic I.D. in jeopardy: the erosion of time, professional values, and physician satisfaction. *Infection* 2015;43:141-4.

4. Edmond MB. Taylorized medicine. *Ann Intern Med* 2010;153:845-6.
5. Hartzband P, Groopman J. Medical Taylorism. *N Engl J Med* 2016;374:106-8.

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## Signs

Caroline Wellbery, M.D., Ph.D.

Not long after my mother died, my father lay disconsolate in a darkened hotel room begging his deceased wife to send him a sign. Wherever she was in her ghostly habitat, would she please smuggle him some affirmation of their enduring love? Suddenly, the overhead light switched on. Other people might have said that signaled her presence. But my father, actually passionately secular, discounted the idea. He did not find this strange electrical event sufficiently convincing: how unimaginative, after all. If my mother were to send notice from the afterlife, she would have chosen something more delicate — perhaps a white petal plucked from one of her beloved cymbidiums, fluttering onto his chest.

When someone dies, the survivors often look for otherworldly messengers. Birds, especially when they hop on a windowsill and peck at the glass, are said to represent ghostly incarnations of the recently departed. It helps if they're ravens, or at least black of wing.

After my father's death, I, too, longed for a sign. But none came, not even in a dream. In the many weeks since he died, I've dreamt of him only once. In that dream,

he sat propped up in a chair, his face wearing the eerily rejuvenated expression that appeared in the hours before his death, when the morphine relaxed and then erased his wrinkles, as though unwinding time. What should I make of this dream? That my father was dead.

So I was left to forge my own signs, hoping to give grief meaning. I'd connect random conversations or events to make sense of my father's death. For example, his second wife, who had angina, had had to go to the hospital for a scheduled cardiac catheterization on the morning of my father's stroke. Terrified that the procedure would go awry, my father had told her the night before, “You mustn't die before I do.” Maybe to secure his place first in line, he took ill.

Or this: One of my father's doctors showed me the CT of his hemorrhagic stroke. The bleed was located in the exact same part of the brain as the one that had afflicted my mother when she had a stroke in 1999. Now my father, like her, was paralyzed on the left side, as though he were demonstrating through imitation his loyalty to her as he followed her to the grave.

Or: How is it that my father

waited to die until my sister and I returned to his hospital room from a several-hour break for eating and showering?

We can't help but look for ways to reconcile ourselves to what is fundamentally unacceptable. In the United States, 7000 people die every day. To paraphrase poet laureate Billy Collins: while you are lying in bed reading your magazine, all the dead of that day are starting their journey.

After my dad's death, I kept telling myself it couldn't be true. Why did he die at 94? Why not at 96? He was, after all, still in great shape. At breakfast, he liked to narrate the formative stories of his youth — how, for example, after he had escaped from Hitler, he'd arrived alone and penniless in an unfamiliar South American town in the middle of the night and had suddenly remembered that distant relatives had migrated there and that they might take him in. He was able to find out where they lived. Awakened by my father's knocking, his cousin rushed to see who it was and immediately folded him into her arms. He was saved.

My father was a storyteller. Just as he could recall the plot of



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SPECIAL REPORT

Public Opinion about the Future of the Affordable Care Act

Robert J. Blendon, Sc.D., and John M. Benson, M.A.

In the early hours of Friday, July 28, the U.S. Senate closed debate on repealing and replacing the Affordable Care Act (ACA) without the passage of any piece of legislation and after rejecting the replacement bill previously passed by the House of Representatives. This public-opinion analysis offers a framework for looking at how the public as a whole saw the issues in this most recent debate.

Our analysis of 27 national opinion polls by 12 survey organizations provides background on four critical issues relevant to the previous House and recent Senate health care decisions: the public favorability of the current law, the public values underlying the debate about the future, support for various health policy changes in the proposed Republican legislation, and support for the overall Republican proposals debated in the House and Senate. Throughout the recent debate, polling organizations have used slightly different samples (either the total number of adults or the total number of registered voters).

Recent studies have shown that the adherents to each of the two political parties have become more divided and polarized in their views of many domestic policy issues, including health care. The divisions in policy preferences between Republicans and Democrats have become so wide that studies of congressional voting behav-

ior often show more congruence with the views of a congressional member's party adherents than with the views of the general public.<sup>1,2</sup> Because Republicans are the majority party in Washington, our analysis pays particular attention to the views of Republicans.

PUBLIC ATTITUDES ABOUT THE ACA

Results from polls on the views of the public about the ACA varied somewhat between the various survey organizations, so we looked at the average of recent polls. This average of polls showed that as of June and July 2017, the public remained split in its assessment of the ACA, but more people approved than disapproved of the law (49% vs. 44%).<sup>3-7</sup> Approval of the ACA increased 5 percentage points between 2012 and the time of the 2017 House and Senate debates<sup>8,9</sup> (Table 1).

Much of the controversial debate in Congress over the need to repeal and replace the ACA (Obamacare) centered on the view by Republican leaders that the law directly hurts many Americans and the position of Democratic leaders that the law needs to be maintained because it directly helps so many Americans. Neither of these positions reflected the point of view of the general public as a whole (Table 2). More respondents

Table 1. Public Approval of the Affordable Care Act (ACA), 2010–2017.\*

Approval of the ACA	ACA Enactment, 2010†	2012†	2014†	2016‡	2017§
Approve	42	44	40	44	49
Disapprove	45	45	51	51	44

\* Data are averages from available polls for each period.

† Data are from Blendon and Benson.<sup>8</sup>

‡ Data are from Blendon et al.<sup>9</sup>

§ Data are from the responses of 1009 U.S. adults, as reported by CNN–ORC, April 2017; 900 U.S. adults, as reported by NBC–Wall Street Journal, June 2017; 1017 registered voters, as reported by Fox, June 2017; 1021 U.S. adults, as reported by Gallup, July 2017; and 1183 U.S. adults, as reported by Kaiser Family Foundation, July 2017.<sup>3-7</sup>

Table 2. Public Assessment of the ACA and Underlying Values, According to Party Identification.*			
Variable	Total Respondents		
	Republicans	Democrats	
percentage of respondents			
Assessment of the ACA			
Effect of the ACA on you†			
Directly helped	24	8	36
Directly hurt	16	31	2
No direct effect	58	60	60
Underlying values			
It is the responsibility of the federal government to make sure all Americans have health care coverage‡			
	60	30	85
Role the federal government should play in improving the U.S. health care system§			
Major role	57	28	87
Minor role	26	43	10
No role	15	28	1
Would you rather see lawmakers ¶			
Make changes so that more people have health insurance, even if it costs the government more money	63	32	89
Make changes to reduce government spending, even if it means fewer people have health insurance	27	56	5
What you would like to see Congress do about the ACA?			
Keep the law as it is	7	4	15
Keep the law in place and work to improve it	51	29	73
Repeal the law and replace it with an alternative	31	50	9
Repeal the law and do not replace it	8	14	1

\* “Don’t know” or “refused” responses are not shown.  
† Data are from the responses of 501 U.S. adults, as reported by Politico–Harvard T.H. Chan School of Public Health (HSPH), June 2017.<sup>10</sup>  
‡ Data are from the responses of 2504 U.S. adults, as reported by Pew Research Center, June 2017.<sup>11</sup>  
§ Data are from the responses of 741 likely voters before the 2016 election, as reported by Politico–HSPH, September 2016.<sup>12</sup>  
¶ Data are from the responses of 1020 registered voters, as reported by Fox, July 2017.<sup>13</sup>  
|| Data are from the responses of 801 U.S. adults, as reported by Monmouth University Polling Institute, March 2017.<sup>14</sup>

reported being helped by the law than hurt by it (24% vs. 16%).<sup>10</sup> The results of the surveys represent the views of millions of people. However, the majority of the public as a whole (58%) and both Republicans (60%) and Democrats (60%) believed that the law had not had a direct effect on them. This suggests that most people’s views about the ACA debate were not based on personal experience but on their beliefs and values about the role of the federal government in extending insurance coverage to those who do not have it.

PUBLIC VALUES UNDERLYING THE DEBATE

Two underlying public values were particularly important here: support for universal coverage and the preferred role for the federal government in health care. When it came to the question of whether the federal government should ensure that all Americans have health care coverage, 6 in 10 respondents (60%) said that it should be the responsibility of the federal government. More than 8 in 10 Democrats (85%)

believed this should be the responsibility of the federal government, whereas only 30% of Republicans agreed.<sup>11</sup> As shown in Figure 1, the percentage of the general public who said that they believed it was the responsibility of the federal government increased from 42% in 2013 to 60% in June 2017.<sup>11,15-18</sup>

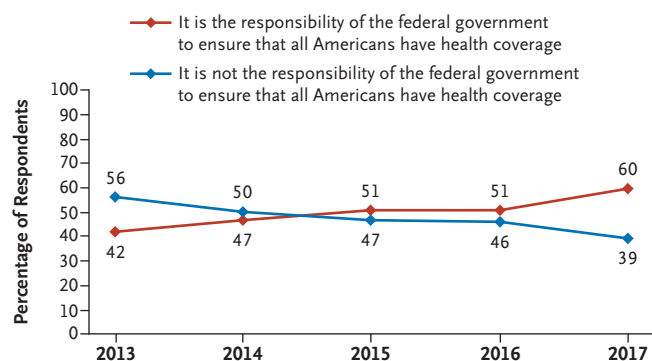
In addition, a majority of persons surveyed (57%) believed that the federal government should play a major role in improving the U.S. health care system, whereas 26% thought it should play a minor role and 15% thought it should play no role at all. Nearly 9 in 10 Democrats (87%) believed the federal government should play a major role in this area, as compared with only 28% of Republicans.<sup>12</sup>

When asked which of two options they would rather see lawmakers choose in the current health care debate, a majority of respondents (63%) preferred that lawmakers make changes so that more people would have health insurance, even if it cost the government more money. Approximately one in four respondents (27%) preferred changes to reduce government spending, even if it meant fewer people would have health insurance. Democrats overwhelmingly preferred more people having health insurance (89%), whereas a majority of Republicans (56%) preferred reducing government spending.<sup>13</sup>

When asked what Congress should do about the ACA, 7% of the public said the ACA should be kept as it was and approximately half (51%) said that the law should be kept in place and that Congress should work to improve it. Approximately 4 in 10 respondents believed Congress should repeal the ACA and either replace it with an alternative (31%) or not replace it at all (8%). Overall, nearly two thirds of Republicans thought the law should be repealed, with half (50%) wanting it repealed and replaced and 14% wanting it repealed and not replaced.<sup>14</sup>

#### PUBLIC VIEWS ABOUT THE COMPONENTS OF A REPEAL- AND-REPLACE BILL

The views of the public about a general principle often differ from their views about specific policy proposals. When we looked at specific aspects of the Republican replacement proposals, some different patterns of public opinion emerged. The



**Figure 1. Respondents' Views about Whether the Federal Government Should Provide Universal Health Insurance Coverage, 2013–2017.**

Data are from the responses of 1039 U.S. adults, as reported by Gallup, November 2013<sup>15</sup>; 3341 U.S. adults, as reported by Pew Research Center, March 2014<sup>16</sup>; 1021 U.S. adults, as reported by Gallup, November 2015<sup>17</sup>; 1130 U.S. adults, as reported by Pew Research Center, March 2016<sup>18</sup>; and 2504 U.S. adults, as reported by Pew Research Center, June 2017.<sup>11</sup>

Republican replacement proposals in both the House and the Senate tended to focus on seven types of changes, shown in Table 3. There were very wide differences between Republicans and Democrats in the general public on nearly every component of the Republican repeal-and-replace proposals.

#### REDUCING THE NUMBER OF PEOPLE RECEIVING SUBSIDIES TO PURCHASE HEALTH INSURANCE

A majority of the general public did not favor changing the law so that it either provided financial assistance for the purchase of health insurance to fewer persons or reduced the number of people to be covered by Medicaid. When asked about the extent of coverage to be provided by a replacement plan, 57% of the public as a whole preferred to provide financial assistance to purchase insurance to the same number of people as the ACA does now, whereas approximately one third preferred to provide assistance to somewhat fewer people (22%) or a lot fewer people (12%) but save taxpayer money.<sup>10</sup>

#### REDUCING THE NUMBER OF MEDICAID RECIPIENTS AND SPENDING

A majority of the public preferred to keep the number of people covered by Medicaid the same as it is now (72%), whereas 22% wanted to reduce the number receiving Medicaid to what it



**Table 3. Public Attitudes about Repeal-and-Replace Legislation, According to Party Identification.\***

Variable	Total Respondents	Republicans	Democrats
<i>percentage of respondents</i>			
<b>Components of a repeal-and-replace bill</b>			
Reducing the no. of people receiving subsidies to purchase health insurance			
Preferred extent of coverage provided by a replacement plan for the ACA†			
Provide financial assistance to purchase insurance to the same no. of people as the ACA does now	57	27	79
Provide assistance to somewhat fewer people but save taxpayer money	22	42	11
Provide assistance to a lot fewer people, saving even more money	12	20	5
Reducing the no. of Medicaid recipients and spending			
Views on proposal by President Trump and congressional Republicans to reduce the no. of people receiving Medicaid‡			
Reduce the no. of people receiving Medicaid to the same no. as before the ACA, reducing the no. receiving Medicaid by millions, but also reducing government spending and taxes	22	46	8
Keep the no. of people covered by Medicaid as it is today	72	52	90
Decrease federal funding for Medicaid‡	31	51	17
Proposal to give states less federal money for Medicaid, but increase flexibility in whom to cover and how to spend the money§			
Prefer more flexibility but less federal money for state governments	37	67	15
Prefer to keep the program as it is now	54	25	83
Ending the individual mandate			
Remove the requirement that people obtain health insurance coverage or pay a penalty¶			
Favor	48	55	38
Oppose	50	45	60
Favor requiring nearly all Americans to have health insurance or else pay a fine¶	35	21	57
Allowing insurers to offer health plans that cover fewer benefits than are currently required			
Allow insurers to offer health plans that cover fewer benefits than are currently required**	35	50	22
Allowing insurers to charge more for people with preexisting conditions			
Allow insurers to charge more for people with preexisting conditions††	24	37	13
Adding cost-reducing restrictions on the current Medicaid program			
Include work requirement in order to receive Medicaid‡‡	68	82	53
Require low-income people receiving Medicaid to make co-payments any time they see a doctor§	42	65	22
Allow states to require people to undergo drug testing to receive and keep Medicaid§§	64	82	47
Allow states to impose limits on the duration of time people can receive Medicaid§§	36	59	19
Ending all federal funding for Planned Parenthood because they provide some abortion services. (Currently the federal government provides funding assistance for some of the services of Planned Parenthood, but not for abortions.)¶¶			
Favor	37	47	29
Oppose	58	48	68

**Table 3. (Continued.)**

Variable	Total Respondents	Republicans	Democrats
<i>percentage of respondents</i>			
<b>Overall assessment of a Republican repeal-and-replace bill</b>			
Approval of Congressional Republican bills			
Approve	24	50	7
Disapprove	56	22	82
Preference between Republican House replacement plan and the ACA***			
Prefer Republican proposal	34	64	11
Prefer to keep the ACA	60	24	85

\* "Don't know" or "refused" responses are not shown.

† Data are from the responses of 501 U.S. adults, as reported by Politico–HSPH, June 2017.<sup>10</sup>

‡ Data are from the responses of 1183 U.S. adults, as reported by Kaiser Family Foundation (KFF), July 2017; 1361 registered voters, as reported by Quinnipiac, June 8, 2017; 1208 U.S. adults, as reported by KFF, June 2017.<sup>7,19,20</sup>

§ Data are from the responses of 525 U.S. adults, as reported by Politico–HSPH, April 2017.<sup>21</sup>

¶ Data are from the responses of 1025 U.S. adults, as reported by CNN–ORC, March 2017.<sup>22</sup>

|| Data are from the responses of 599 U.S. adults, as reported by KFF, November 2016.<sup>23</sup>

\*\* Data are from the responses of 1208 U.S. adults, as reported by KFF, June 2017; 494 U.S. adults, as reported by Politico–HSPH, April 2017.<sup>20,21</sup>

†† Data are from the responses of 501 U.S. adults, as reported by Politico–HSPH, June 2017; 1208 U.S. adults, as reported by KFF, June 2017; 1004 U.S. adults, as reported by Washington Post–ABC, April 2017; 1078 registered voters, as reported by Quinnipiac, May 2017.<sup>10,20,24,25</sup>

‡‡ Data are from responses of 1208 U.S. adults, as reported by KFF, June 2017; 525 U.S. adults, as reported by Politico–HSPH, April 2017.<sup>20,21</sup>

§§ Data are from the responses of 1208 U.S. adults, as reported by KFF, June 2017.<sup>20</sup>

¶¶ Data are from the responses of 741 likely voters before the 2016 election, as reported by Politico–HSPH, September 2016.<sup>12</sup>

||| Data are from the responses of 900 U.S. adults, as reported by NBC–Wall Street Journal, June 2017; 1183 U.S. adults, as reported by KFF, July 2017; 1020 registered voters, as reported by Fox, July 2017; 1002 U.S. adults, as reported by Monmouth University Polling Institute, May 2017; 1117 U.S. adults, as reported by CBS, June 2017; 1205 U.S. adults, as reported by NPR–PBS–Marist, June 2017; 1212 registered voters, as reported by Quinnipiac, June 28, 2017.<sup>4,7,13,26-29</sup>

\*\*\* Data are from the responses of 494 U.S. adults, as reported by Politico–HSPH, April 2017.<sup>21</sup>

was before the ACA, reducing government spending and taxes.<sup>10</sup>

An average of polls showed that 31% of the public favored reducing federal funding for Medicaid.<sup>7,19,20</sup> In addition, less than 4 in 10 respondents (37%) favored giving states less federal money for Medicaid but increasing their flexibility in whom to cover and how to spend the money.<sup>21</sup>

#### ENDING THE INDIVIDUAL MANDATE

On the issue of removing the requirement under the ACA that people obtain health insurance coverage or pay a penalty, the overall public was divided. A total of 48% favored removing this requirement, whereas 50% were opposed.<sup>22</sup> In late 2016, before the start of the congressional debate, only 35% of the public had a favorable opinion of the individual mandate.<sup>23</sup>

#### ALLOWING INSURERS TO OFFER HEALTH PLANS THAT COVER FEWER BENEFITS

Approximately one third of the public (35%) believed that insurers should be allowed to offer

health plans that cover fewer benefits than currently required.<sup>20,21</sup>

#### ALLOWING INSURERS TO CHARGE MORE FOR PEOPLE WITH PREEXISTING CONDITIONS

On the issue of ending federal health insurance regulatory protections for people who have preexisting medical conditions, less than one fourth of the public believed that insurers should be allowed to charge more for people with preexisting conditions (24%).<sup>10,20,24,25</sup>

Other issues in the debate included adding cost-reducing restrictions to the current Medicaid program<sup>20,21</sup> and ending all federal funding for Planned Parenthood.<sup>12</sup> Table 3 shows the results of polling on those issues.

#### OVERALL PUBLIC ASSESSMENT OF THE REPUBLICAN REPEAL-AND-REPLACE BILLS

Overall, only approximately one in four of the respondents (24%) approved of the congressional Republican plan (or plans, since they include

both the plan that passed in the House and the proposals put forth in the Senate) to repeal and replace the ACA, whereas 56% disapproved. Fully one in five respondents did not have an opinion.<sup>4,7,13,26-29</sup>

From the point of view of public opinion, the Republican replacement plans were extraordinarily unpopular. When Medicare was first enacted in 1964, it was supported by 61% of the public.<sup>30</sup> Support for the ACA was lower, but as Table 1 shows, the rate of support was 42% at the time of its enactment and in June and July it stood at 49%. By contrast, only 24% of the public approved of the Republican replacement plans, and more than twice as many disapproved. Even though a majority of Republicans favored repealing the ACA, only half (50%) approved of the replacement bills. Still, given a choice between the House replacement plan and Obamacare, nearly two thirds (64%) of Republicans preferred the replacement plan.<sup>21</sup>

The views of Republicans are particularly important here. As shown in Table 2, nearly two thirds of Republicans (64%) wanted to repeal the ACA.<sup>14</sup> With regard to beliefs and values, only a minority of Republicans believed that it was the responsibility of the federal government to ensure that all Americans have health care coverage (30%) or that the federal government should play a major role in improving health care in the United States (28%).<sup>11,12</sup> Likewise, only a minority of Republicans preferred providing financial assistance to purchase health insurance to the same number of people as the ACA does now (27%)<sup>10</sup> or making changes so that more people have health insurance if it costs the government more money (32%).<sup>13</sup>

Reflecting the difficulty in reaching a consensus among Republicans in Congress were the deep divisions among Republicans on many of the specific components of their own replacement proposals. A slight majority of Republicans (52%) wanted to keep the number of people covered by Medicaid the same as it is today rather than reducing the number to what it was before the ACA.<sup>10</sup> Approximately half of Republicans (51%) favored decreased federal funding for Medicaid, allowing insurers to offer health plans that cover fewer benefits than are currently required (50%),<sup>20,21</sup> and ending all federal funding for Planned Parenthood (47%).<sup>12</sup>

In addition to these divisions, only 37% of Republicans favored allowing insurers to charge more for people with preexisting conditions.<sup>10,20,24,25</sup> However, one in seven Republicans (14%) still wanted to repeal the ACA without replacing it at all.<sup>14</sup>

Taken together, these fundamental divisions among Republicans point to an underlying reason why Republicans in Congress had such difficulty agreeing on a single repeal-and-replace plan. These divisions were not helped by the fact that President Donald Trump's role in the debate was seen so poorly by the general public, with only 28% approving of his handling of health care.<sup>31</sup>

## CONCLUSIONS

What are the insights we can learn from polls during the recent congressional debate? The first insight is that the Republican Party, which is in the majority in Washington, is much more divided on health care issues than was recognized at the time of President Trump's election, so it is difficult to enact major legislation.

The second insight is how polarized Republicans and Democrats are about the overall future of the ACA. Throughout the debate, the majority of Republican adherents favored repealing the ACA, whereas Democrats did not. This made it very difficult to have any compromise legislation. Not widely recognized is that one of the reasons no bill was ultimately enacted was the split among Republicans between repealing and replacing the ACA or repealing it without a replacement.

On most specific policy issues in the debate, Republicans and Democrats disagreed, but there is one major exception. The two parties' adherents agree that the number of people covered by Medicaid should not be reduced in any replacement bill.

Finally, the most important change over time was not the increase in public approval of the ACA, but rather the increase in overall support for universal coverage. When confronted with millions of people losing coverage, the public became more supportive of the principle that the federal government should ensure coverage for them.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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# VA Secretary's Stand-Up Brief

29 August 2017

## Executive Summary

The reporting period saw sustained supportive coverage of Secretary Shulkin and the Department's role in the Hurricane Harvey response. The Oklahoma VAMC storyline following the discovery of a deceased Veteran saw some further developments.

Storyline	Outlets	Analysis	Trend	MyVA Priority
Secretary Shulkin accomplishments	<a href="#">Politico</a> , <a href="#">Forward</a> , <a href="#">Washington Free Beacon</a>	Additional supportive coverage followed weekend reporting by <i>CBS News</i> . <i>Politico</i> also profiled the Secretary's accomplishments toward reforming the Department.	<b>Sustained</b>	Experience
'New' VA wait list	<a href="#">FOX News</a>	<i>FOX</i> described the wait to see non-VA doctors faced by Veterans at the Overton Brooks VAMC as a 'new wait list' problem. Issues with the wait, outlined by a facility whistleblower, sent to the president, and forwarded to the office of whistleblower protection, resulted in a positive response to the employee's concerns. <i>FOX</i> noted "that dozens of employees, including managers, worked overtime on the weekend trying to help the Veterans on the list." The overall tone of the story was supportive and it received some syndication to smaller outlets.	<b>Emerged</b>	Access
VA involvement in Hurricane Harvey	<a href="#">WFED (AM)</a> , <a href="#">KARK (NBC)</a> , <a href="#">WWTV (CBS)</a>	An additional narrative in coverage of the Hurricane relief effort emerged to follow how VA has partnered with other federal agencies ( <i>WFED</i> ). Coverage of the call center in Little Rock also continued.	<b>Sustained</b>	Partnership / Access
Veteran found dead in stairwell of OKC VAMC	<a href="#">KOCO (ABC)</a>	The family of Larry Harris, who was found dead in an OKC VAMC stairwell after going missing for eight hours, want an explanation from VA. Coverage includes a response from VA similar to those included in initial coverage last week.	<b>Sustained</b>	Access
VA uses surveys to improve customer experience	<a href="#">WFED (AM)</a>	Brian Michael, general manager of Medallia's public sector practice discussed how VA is using survey data to create feedback loops that improve the customer service experience for Veterans on the 'Federal Drive' program.	<b>Emerged</b>	Experience



# VA Secretary's Stand-Up Brief

29 August 2017

## Social Media Takeaway

Lower social media volume followed VA's role in the federal response to Hurricane Harvey. A post from Secretary Shulkin featured in this activity.

## Key Points

- The [post](#) from Secretary Shulkin highlighting the Department's role in the Hurricane response was the second most-retweeted of the period and was solely responsible for VA-related mentions of #Harvey (110+). General discussion of this topic and retweets of other @SecShulkin and VA posts centered on #HurricaneHarvey, which also garnered 110+ mentions.
- A tweet from [@votevets](#) garnered the most retweets during the period, more than doubling the Secretary's hurricane post. This post criticized the president and the GOP for expanding the "failing" Choice Program at the expense of Veterans.
- Residual activity focused on the unfortunate events at Charlottesville sustained in VA social media. The most notable example of this was a minor trend seen by a [post](#) that linked to [New York Daily News](#) reporting detailing WWII Veteran disgust at the "surge of neo-Nazis" seen in Charlottesville. This post drove minor VA-related usage of several hashtags: #neoNazi, #Dunwoody, #DonaldTrump, #gapol, and #KKK.
- Facebook activity continued to experience low levels of user engagement as typified by the typically popular [Veteran of the Day](#) feature, which did not reach above 500+ mentions.



#StudentVets affected by #HurricaneHarvey, our friends at GIBill have important info: [facebook.com/notes/the-post](https://facebook.com/notes/the-post) ...

Follow

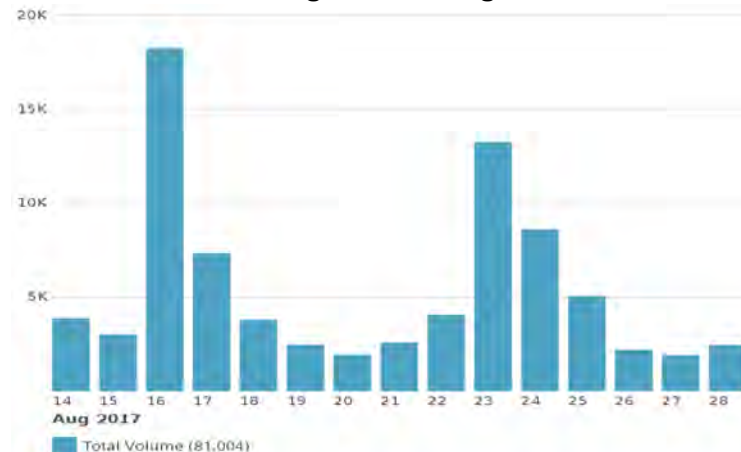


Houston VA remains open "for our vets who need us" but "roads around the MC are impassable"  
[houston.va.gov/emergency/inde...](https://houston.va.gov/emergency/inde...)  
 #HurricaneHarvey

Follow

## Twitter and Facebook Volume:

14 August – 28 August



## Notable Social Media Items

Platform	Item	Relevance
Twitter	#HurricaneHarvey / #Harvey	110+ Mentions each
Twitter	<a href="#">Post: Trump &amp; GOP expansion of failing Choice would seek to profit from Veterans</a>	220+ Retweets
Facebook	<a href="#">Veteran of Day: Matthew Sean Neely</a>	490+ Reactions, 110+ Shares

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Attachment  
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10/10/2017

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Cc:  
Bcc:  
Subject: Secretary's Stand-Up - OPIA (Aug. 23, 2017)  
Date: Wed Aug 23 2017 07:30:22 CDT  
Attachments: 170823\_VA Secretary's Stand-Up Brief.pptx

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Ladies and gentlemen,

Good morning! Attached is today's Stand-Up Brief for your review.

Sincerely,

(b) (6)

Media Relations Division

Office of Public & Intergovernmental Affairs

Department of Veterans Affairs

810 Vermont Ave., NW, Suite 913J

Washington, DC 20420

(b) (6)@va.gov

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"Pursue, engage and impact a Veteran today!"

---

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Filename: 170823\_VA Secretary's Stand-Up Brief.pptx  
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# VA Secretary's Stand-Up Brief

23 August 2017

## Executive Summary

Low coverage volume continued as non-VA storylines sustained outlets' attention. Local coverage was the most prominent of the period, with notable storylines coming out Reno, Nev., Milwaukee, Wis., and Columbus, Ohio.

Storyline	Outlets	Analysis	Trend	MyVA Priority
President Trump and Secretary Shulkin in Reno, Nev.	<a href="#">Reno Gazette-Journal</a> , <a href="#">KOLO (ABC)</a>	Coverage referenced the progress made on VA legislation under President Trump leading up to his remarks at American Legion's national convention Wednesday. Local outlets also followed Secretary Shulkin's Tuesday visit to the city and his signing of the "Be There" resolution aimed at preventing Veteran suicide – a message that trended in social media. <i>KOLO</i> specifically followed the Secretary's visit to local VA.	<b>Emerged</b>	Experience / Other
OIG reviews opioid prescribing at Milwaukee VAMC	<a href="#">Milwaukee Journal Sentinel</a>	VA released a statement of support for an unnamed physician after the IG called for a panel to review their opioid prescribing practices. The majority of the article detailed the prior OIG investigation conducted at the Clement J. Zablocki VAMC between 2015 – 2017.	<b>Emerged</b>	Access
Camp Chase Cemetery Confederate statue vandalized	<a href="#">Columbus Dispatch</a> , <a href="#">WCMH (NBC)</a> , <a href="#">WSYX (ABC)</a>	Reporting featured a VA statement released in response to the vandalism directed at bronze statue of a soldier at the Camp Chase Confederate Cemetery on Tuesday. Coverage tended to make limited reference to VA outside of the statement.	<b>Emerged</b>	Experience
Secretary Shulkin in Montana	<a href="#">Washington Examiner</a>	While this storyline declined, a new narrative emerged in commentary from <i>Washington Examiner</i> following VA police officer and whistleblower Greg Chiles who claims retaliation against him continues, despite a Department policy.	<b>Declined</b>	Experience



# VA Secretary's Stand-Up Brief

23 August 2017

## Social Media Takeaway

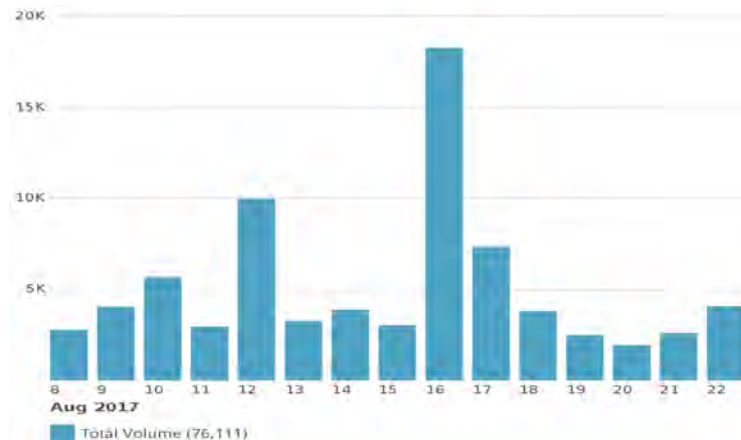
Volume rebounded from the lows seen during the prior two reporting periods as President Trump's speech trended in the top-retweeted posts.

## Key Points

- Several of the period's top-retweeted items referenced the President and his remarks on Veterans during his evening speech in Phoenix:  
[@The\\_Trump\\_Train](#) referenced the 500+ VA employees fired since Trump took office (320+ RTs); and [@FoxNews](#) posted a pair of tweets with the same text about VA reform and their video coverage of the Reno event (130+ & 100+ RTs).
- [Secretary Shulkin](#) generated a notable trend with his tweet reaffirming suicide prevention as his top clinical priority. While the post itself only garnered 30+ retweets, responses to it and follow on discussion grew this activity to 150+ posts and constituted four percent of total volume.
- The video of the [#ExploreVA Facebook Live](#) event gained 26k views. This post was notable for the high-degree of VA interaction with users in the comments section and the more supportive than typical tone of the video comments in general.
- With 470+ RTs, the [top post](#) of the period featured a link to [FOX News coverage](#) and was very supportive of a Philadelphia effort to build tiny homes from Homeless Veterans.
- User [@charliekirk11](#) was critical of VA in general, calling it a "socialized disaster" (350+ RTs) in response to a 21 August post from [@SenSanders](#) about his new healthcare bill – which had much greater user traction and garnered a total 3.8k RTs.
- On YouTube, a [VA video message](#) on VSOs and the Department working together in a commitment to improve transparency and accountability experienced a minor trend and gained 750+ views.

## Twitter and Facebook Volume:

8 August – 22 August



## Notable Social Media Items

Platform	Item	Relevance
Twitter	<a href="#">Top Post: Tiny homes for Veterans a great idea</a>	470+ Retweets
Twitter	<a href="#">Secretary Shulkin: Suicide prevention remains top clinical priority</a>	4% of Volume
Facebook	<a href="#">#ExploreVA Facebook Live event</a>	26k Views, 600+ Reactions, 260+ Shares

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Date: Mon Aug 21 2017 07:30:59 CDT  
Attachments: 170821\_VA Secretary's Stand-Up Brief.pptx

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Ladies and gentlemen,

Good morning! Attached is today's Stand-Up Brief for your review.

Sincerely,

(b) (6)

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"Pursue, engage and impact a Veteran today!"

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# 21 August 2017

VA-specific storylines steeply declined during the weekend at both the national and local level. Outlets however wrote extensively on Veterans and Charlottesville in non-VA storylines.

Storyline	Outlets	Analysis	Trend	MyVA Priority
Sec. Shulkin on Charlottesville	<a href="#"><i>Washington Post</i></a> , <a href="#"><i>The Hill</i></a> , <a href="#"><i>FOX News</i></a>	VA was mostly absent from Charlottesville, which dominated weekend coverage. A <i>Washington Post</i> opinion, reprinted by multiple outlets, positively mentioned the Secretary in an otherwise highly critical piece. In an article summarizing the debate over the President's comments, <i>The Hill</i> quoted Secretary Shulkin from his <i>FOX News</i> interview with Jesse Watters. The original interview also addressed VA accountability and the mental health crisis.	Sustained	Other / Experience / Access
Removing Confederate statues from National Cemeteries	<a href="#"><i>Washington Post</i></a> , <a href="#"><i>AP</i></a>	During the weekend, calls for removing the statues were not observed for NCA-run cemeteries. However, a very popular <i>AP</i> article summarized a <i>Washington Post</i> story on the family of Confederate sculptor Moses Jacob Ezekiel calling for removals from Arlington National Cemetery.	Sustained	Other
Sec. Shulkin on <i>Government Matters</i>	<a href="#"><i>Government Matters</i></a>	Secretary Shulkin covered multiple Experience, Access, and Partnership topics in this fourteen-minute interview.	Emerged	Experience / Access / Partnerships
President signs Forever GI Bill	<a href="#"><i>San Diego Union-Tribune</i></a> , <a href="#"><i>WBOC (CBS)</i></a> , <a href="#"><i>Times-Standards</i></a>	This storyline continued declining with most stories focusing on the bill's impact on local Veterans. <i>San Diego Union-Tribune</i> published a brief editorial titled "Lost in the chaos, a great display of unanimity" which celebrated the bipartisan support of the Forever GI Bill and outlined the provisions. <i>WBOC</i> highlighted the benefits for Delaware Veterans, and <i>Times-Standard</i> for California Veterans.	Declined	Experience
OIG on deficiencies in enrollment procedures	<a href="#"><i>Topeka Capital-Journal</i></a>	This article covered an unspecified OIG report that purportedly found over 658k applications for VA enrollment remain in pending status. The outlet claimed it obtained an internal VA email suggested administrators were in the process of rolling out 400-500k application closure letters this month. Messaging came from Acting Dir. of Member Services Matt Eitutis, Dan Caldwell, and Scott Davis.	Long- Term	Access
Tucson VA: public records request and recruiting dermatologists	<a href="#"><i>AP</i></a> , <a href="#"><i>Arizona Daily Star 1, 2</i></a>	<i>AP</i> publicized the <i>Arizona Daily Star 1</i> article on VA's OGC overturning the Tucson VA's denial of the newspaper's public records request for the names of the hospital's specialty staff. Separately, <i>Arizona Daily Star 2</i> detailed the local dermatologist shortage.	Emerging	Experience / Access



# VA Secretary's Stand-Up Brief

21 August 2017

## Social Media Takeaway

Social media volume on Sunday dropped to the lowest level since mid-June 2017. The tweet by @RealJamesWoods accounted for 18% of weekend volume.

## Key Points

- @RealJamesWoods tagged #Veterans and compared the \$400k spent on a study by the NIH on excessive drinking in the LGBTQ community to money for more beds in VA hospitals (2.7k+ RTs and 5.1k+ likes).
- President Trump's [16 August tweet](#) on the signing of the Harry W. Colmery Veterans Educational Assistance Act of 2017 was the second most-retweeted weekend post, reaching a total of 13.6k+ RTs and 57k+ likes.
- @GOP tagged @POTUS and @SecShulkin in its message above a photo (no link) of an AP article on Veterans getting expanded GI Bill benefits under President Trump (180+ RTs).
- In two separate posts, each with 150+ RTs, @SecShulkin promoted the #ForeverGIBill and the #Thunderclap campaign.
- @FoxNews [quoted](#) the Secretary from his interview with Jesse Watters (170+ RTs).
- Journalist H.A. Goodman interviewed whistleblower Tarref Simon on claims of dirty water and retaliation by the Michael E. DeBakey VAMC, which was outlined in a *SE Texas Record* [article](#) from 28 Nov. 2016.

**James Woods** @RealJamesWoods

How many beds could this money have provided at a VA Hospital for our neglected #veterans?

**GOP** @GOP

@POTUS, @SecShulkin are committed to ensuring our vets have access to the benefits and education they rightfully deserve.

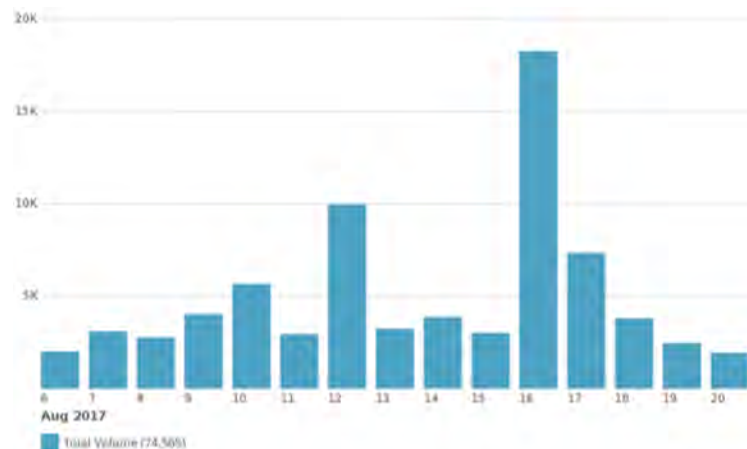
**Dr. David J. Shulkin** @SecShulkin

The #ForeverGIBill is just the latest piece of legislation signed by @POTUS that helps our #Veterans  
[radio.foxnews.com/2017/08/17/dr- ...](http://radio.foxnews.com/2017/08/17/dr-...) via @FoxNews

**Dr. David J. Shulkin** @SecShulkin

Join our #Thunderclap campaign to let people know that preventing suicide starts with this simple act of support

## Twitter and Facebook Volume: 8 August – 20 August



## Notable Social Media Items

Platform	Item	Relevance
Twitter	#Veterans	23% of Volume
Twitter	@SecShulkin	20% of Volume
YouTube	<a href="#">Veterans Administration Whistleblower Tarref Simon Exposes Organs Stored In Dirty Water: Interview</a>	5.4k+ Views
Facebook	<a href="#">5 Things for Veterans to Know About Expanded GI Benefits</a>	1.2k+ Reactions, 730+ Shares

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Subject: Secretary's Stand-Up - OPIA - August 18, 2017  
Date: Fri Aug 18 2017 06:41:47 CDT  
Attachments: 170818\_VA Secretary's Stand-Up Brief.pptx

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Good morning.

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# VA Secretary's Stand-Up Brief

## 18 August 2017

### Executive Summary

More attention returned to the GI Bill storyline as coverage of Secretary Shulkin's reaction to the behavior of Nazis and white supremacists in Charlottesville declined. Local and some smaller national outlets continued to follow the Buffalo endoscopy infection risk storyline.

Storyline	Outlets	Analysis	Trend	MyVA Priority
President signed Mustard gas exposure bill	<a href="#">FOX News</a> , <a href="#">AP</a>	While this storyline had emerged in the prior period, it was overshadowed by coverage of the GI Bill and the Secretary's Charlottesville remarks. During this reporting period, coverage dramatically expanded with the addition of <i>AP</i> and <i>FOX News</i> articles – both of which were syndicated across local outlets.	<b>Sustained</b>	Access
Patients face infection risk from improperly cleaned scopes	<a href="#">Buffalo News</a> , <a href="#">WGRZ (NBC)</a> , <a href="#">Becker's</a> , <a href="#">Fierce Healthcare</a>	<i>Buffalo News</i> followed up its previous coverage of the infection risk posed to over 500 patients and reported concerns expressed by two New York Congressmen in the wake of the alert about the medical scopes. <i>WGRZ</i> reported that a request to the Buffalo VA for further information on how and when patients will be notified went unanswered.	<b>Sustained</b>	Access
President signs "Forever GI Bill	<a href="#">AP</a> , <a href="#">VICE News</a> , <a href="#">FOX News Radio</a> , <a href="#">WCPO (ABC)</a>	Storyline volume largely sustained on the strength of continued reprints of the prior period's <a href="#">AP coverage</a> and syndication of a second, updated <i>AP</i> article. The 'Brian Kilmeade Show' on <i>FOX News Radio</i> featured an interview with the Secretary about the new GI Bill. However, the later part of the interview once again shifted to discuss his remarks on Charlottesville. Despite continued attention to Charlottesville, the GI Bill gained prominence in social media, constituting the largest share of volume.	<b>Sustained</b>	Experience
Sec. Shulkin "outraged" by Nazi and white supremacist behavior	<a href="#">New York Daily News</a> , <a href="#">JTA</a>	While this storyline declined, it remained prominent in social media. The commentary piece from <i>New York Daily News</i> reiterated the theme calling on Secretary Shulkin to resign.	<b>Declined</b>	Other



# VA Secretary's Stand-Up Brief

## 18 August 2017

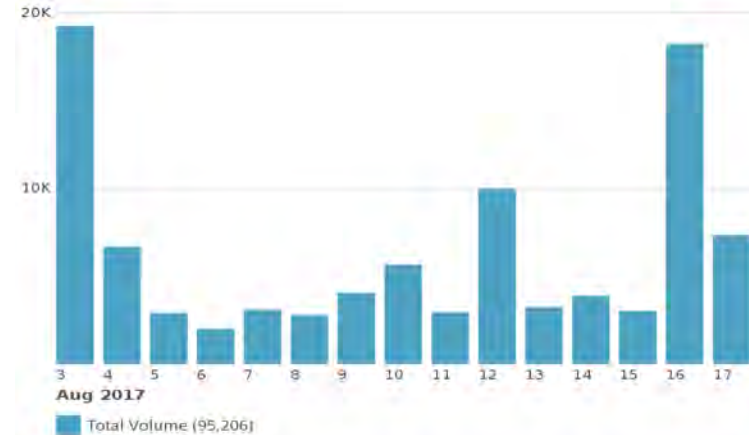
### Social Media Takeaway

Volume declined by more than half after the surge of activity due to the signing of the new GI Bill and Secretary Shulkin's remarks on hate groups began to fade. However, these two topics' share of overall volume increased as they continued to constitute the majority of activity.

### Key Points

- President Trump's [16 August tweet](#) marking the signing of the Harry W. Colmery Veterans Educational Assistance Act of 2017 remained the top retweeted post, while it garnered an additional 2.1k RTs. It also continued to contribute the bulk of activity to reference the new "Forever" GI Bill.
- Similarly, Secretary Shulkin's own posts continued to be the primary driver of VA-related mentions of #ForeverGIBill (180+), with his [top post](#) for the period using the hashtag and gaining 70+ mentions.
- Activity referencing Secretary Shulkin's statement on Nazi and white supremacist behavior at Charlottesville continued to frequently feature the "It is a dishonor to our country's veterans to allow the Nazis and the white supremacists to go unchallenged" quote. A new theme in activity pointed his statements to show the Secretary ['broke ranks'](#) with the White House by saying that "Staying silent on these issues is simply not acceptable."
- For a third consecutive period, VBA's Facebook page sustained its trend of higher user engagement with one of its [most popular posts to date](#) (1k reactions) when they shared an item from the [Post-9/11 GI Bill](#) page (original 650+ reactions and 1.2k shares) on the new GI Bill.
- The main VA Facebook page 65210salso gained notable user engagement with a [post](#) about an American WWII Veteran who returned a Japanese flag taken from a fallen soldier to that soldier's family.

### Twitter and Facebook Volume: 3 August – 17 August



### Notable Social Media Items

Platform	Item	Relevance
Twitter	Topic: President signs "Forever" GI Bill	75% of Volume
Twitter	Topic: Secretary Shulkin "outraged" by Nazis and white supremacists	23% of Volume
Facebook	<a href="#">"Forever" GI Bill signed into law</a>	1k Reactions, 70+ Saves
Facebook	<a href="#">U.S. WWII vet returns flag to fallen Japanese soldier's family</a>	810+ Reactions, 110+ Shares

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Cc:  
Bcc:  
Subject: Secretary's Stand-up - OPIA - August 17  
Date: Thu Aug 17 2017 07:29:00 CDT  
Attachments: 170817\_Brief.pptx

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Good Morning

(b) (6)

Office of Media Relations

Office of Public and Intergovernmental Affairs

U.S. Department of Veterans Affairs

Direct: (b) (6) | Main: 202.461.7600

(b) (6) @va.gov

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Last Modified: Thu Aug 17 07:29:00 CDT 2017

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# VA Secretary's Stand-Up Brief

17 August 2017

## Executive Summary

National coverage featured the intermingled storylines following the signing of the "Forever" GI Bill and Secretary Shulkin's personal outrage at the behavior of Nazis and white supremacists at Charlottesville.

Storyline	Outlets	Analysis	Trend	MyVA Priority
Sec. Shulkin "outraged" by Nazi and white supremacist behavior	<a href="#">Washington Post</a> , <a href="#">AP</a> , <a href="#">The Hill</a> , <a href="#">New York Times</a> , <a href="#">Reuters</a> , <a href="#">Wash. Times</a> , <a href="#">NJ.com</a> , <a href="#">Washington Examiner</a>	Coverage of the Secretary's response to the broader questioning of administration officials over their reaction to the President's controversial remarks Tuesday, proved to be largely supportive. Some critical tone did follow what was described as the Secretary's refusal to fault the President for equating the violence of counter protestors with that of Nazis and white supremacists. However, outlets extensively noted Shulkin's personal "outrage" at the behavior of Nazis and white supremacists, as well as his urging that they must be confronted. More often coverage focused on Shulkin's remarks in preference to his disinclination to criticize President Trump. Social media trended with activity, frequently referencing a specific quote from the Secretary's remarks.	<b>Emerged</b>	Other
President signs "Forever" GI Bill	<a href="#">AP</a> , <a href="#">Stars and Stripes</a> , <a href="#">U.S. News &amp; World Report</a> , <a href="#">PBS</a> , <a href="#">San Diego Union-Tribune</a>	Coverage detailed the provisions of the new law signed by the president. Reporting included stakeholder reactions and quotes from Secretary Shulkin. However, attention on this supportive storyline and VA messaging was diverted by a focus on the prior storyline following Shulkin's remarks on Charlottesville. Retweets of a presidential tweet about the bill signing did feature prominently in social media.	<b>Emerged</b>	Experience
Patients face infection risk from improperly cleaned scopes	<a href="#">Buffalo News</a> , <a href="#">WIVB (CBS)</a> , <a href="#">WKBW (ABC)</a>	Buffalo outlets reported that 526 patients are at risk of infection after the it was discovered that an improperly cleaned medical scope was used in their procedures. Coverage noted that an employee was "immediately relieved" of their position and went on to give an overview of concern about infections linked to endoscopes.	<b>Emerged</b>	Access
Wilkes-Barre nurse could have charges dropped	<a href="#">AP</a> , <a href="#">Times Leader</a>	The former Wilkes-Barre nurse that was charged with endangerment, for assisting in an operation after consuming alcohol, could see those charges dropped now that he has completed a federal diversion program.	<b>Emerged</b>	Experience
Lebanon VA surgeon helps Veterans live normal lives	<a href="#">AP</a>	AP syndicated a supportive 11 August profile of Lebanon orthopedic surgeon Rex Herbert that originally appeared in the <a href="#">Lebanon Daily News</a> .	<b>Sustained</b>	Access

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# VA Secretary's Stand-Up Brief

17 August 2017

## Social Media Takeaway

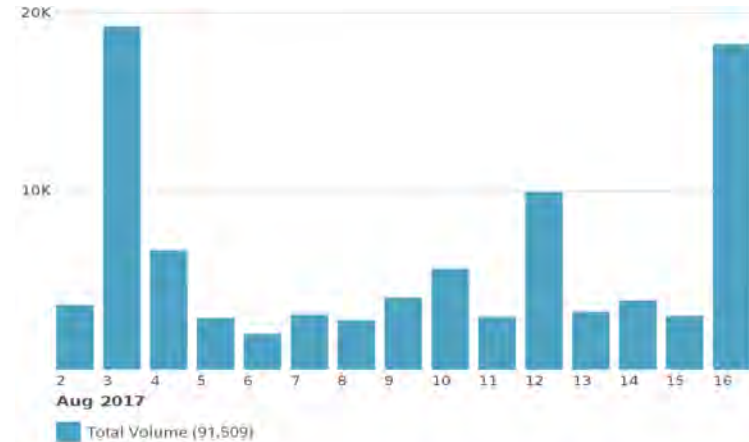
Volume surged with the President's post on his signing of the new GI Bill and as users reacted to Secretary Shulkin's remarks on Charlottesville.

## Key Points

- President Trump garnered over 4.6k RTs of his [post](#) marking the signing of the Harry W. Colmery Veterans Educational Assistance Act of 2017 with Secretary Shulkin in attendance. This tweet alone constituted just under a third of period volume.
- Secretary Shulkin's own [tweet](#) about the signing was his account's top post of the day with 140+ RTs and was the primary driver of #ForeverGIBill (190+), which was the second most-popular hashtag.
- As with traditional media, VA messaging on the GI Bill signing was overtaken by reactions to Secretary Shulkin's statements expressing outrage at the actions of Nazis and white supremacists. Five of the top ten retweeted posts referenced these remarks, with several citing a specific quote from Shulkin: "It is a dishonor to our country's veterans to allow the Nazis and the white supremacists to go unchallenged." While secondary activity included much supportive content, there was a notable theme of criticism in users' reactions that faulted the Secretary for failing to resign in protest.
- YouTube videos tended to combine the GI Bill signing with the Secretary's remarks on white nationalism by featuring the entire White House briefing on the GI Bill. The [most popular](#) of these gained 7.6k views. Additionally, these clips were often embedded in tweets focusing on Shulkin's "dishonor" quote.
- On Facebook, VBA sustained its trend of posts with elevated user engagement, with one linking to coverage [of Amazon.com's plans](#) to sell MREs garnering 440+ reactions. The main VA page reversed its trend of lower user engagement during the period with a post on the [75th anniversary](#) of the 101st Airborne Division, which saw 840+ reactions.

## Twitter and Facebook Volume:

2 August – 16 August



## Notable Social Media Items

Platform	Item	Relevance
Twitter	Topic: President signs "Forever" GI Bill	31% of Volume
Twitter	Topic: Secretary Shulkin "outraged" by Nazis and white supremacists	28% of Volume
YouTube	<a href="#">Golden State Times: Sec. Shulkin on H.R. 3218</a>	7.6k Views
Facebook	<a href="#">75th Anniversary of 101st Airborne division</a>	840+ Reactions, 220+ Shares

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administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)  
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Cc:  
Bcc:  
Subject: Veterans Affairs Secretary's Stand-Up Brief for Aug. 17  
Date: Thu Aug 17 2017 07:33:03 CDT  
Attachments: 170817\_VA Secretary's Stand-Up Brief.pptx

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Good morning,

Sharing today's VA Secretary's Stand-up Brief.

Very Respectfully,

(b) (6)

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# VA Secretary's Stand-Up Brief

17 August 2017

## Executive Summary

National coverage featured the intermingled storylines following the signing of the "Forever" GI Bill and Secretary Shulkin's personal outrage at the behavior of Nazis and white supremacists at Charlottesville.

Storyline	Outlets	Analysis	Trend	MyVA Priority
Sec. Shulkin "outraged" by Nazi and white supremacist behavior	<a href="#">Washington Post</a> , <a href="#">AP</a> , <a href="#">The Hill</a> , <a href="#">New York Times</a> , <a href="#">Reuters</a> , <a href="#">Wash. Times</a> , <a href="#">NJ.com</a> , <a href="#">Washington Examiner</a>	Coverage of the Secretary's response to the broader questioning of administration officials over their reaction to the President's controversial remarks Tuesday, proved to be largely supportive. Some critical tone did follow what was described as the Secretary's refusal to fault the President for equating the violence of counter protestors with that of Nazis and white supremacists. However, outlets extensively noted Shulkin's personal "outrage" at the behavior of Nazis and white supremacists, as well as his urging that they must be confronted. More often coverage focused on Shulkin's remarks in preference to his disinclination to criticize President Trump. Social media trended with activity, frequently referencing a specific quote from the Secretary's remarks.	<b>Emerged</b>	Other
President signs "Forever" GI Bill	<a href="#">AP</a> , <a href="#">Stars and Stripes</a> , <a href="#">U.S. News &amp; World Report</a> , <a href="#">PBS</a> , <a href="#">San Diego Union-Tribune</a>	Coverage detailed the provisions of the new law signed by the president. Reporting included stakeholder reactions and quotes from Secretary Shulkin. However, attention on this supportive storyline and VA messaging was diverted by a focus on the prior storyline following Shulkin's remarks on Charlottesville. Retweets of a presidential tweet about the bill signing did feature prominently in social media.	<b>Emerged</b>	Experience
Patients face infection risk from improperly cleaned scopes	<a href="#">Buffalo News</a> , <a href="#">WIVB (CBS)</a> , <a href="#">WKBW (ABC)</a>	Buffalo outlets reported that 526 patients are at risk of infection after the it was discovered that an improperly cleaned medical scope was used in their procedures. Coverage noted that an employee was "immediately relieved" of their position and went on to give an overview of concern about infections linked to endoscopes.	<b>Emerged</b>	Access
Wilkes-Barre nurse could have charges dropped	<a href="#">AP</a> , <a href="#">Times Leader</a>	The former Wilkes-Barre nurse that was charged with endangerment, for assisting in an operation after consuming alcohol, could see those charges dropped now that he has completed a federal diversion program.	<b>Emerged</b>	Experience
Lebanon VA surgeon helps Veterans live normal lives	<a href="#">AP</a>	AP syndicated a supportive 11 August profile of Lebanon orthopedic surgeon Rex Herbert that originally appeared in the <a href="#">Lebanon Daily News</a> .	<b>Sustained</b>	Access

VA-17-0334-A-000273



# VA Secretary's Stand-Up Brief

17 August 2017

## Social Media Takeaway

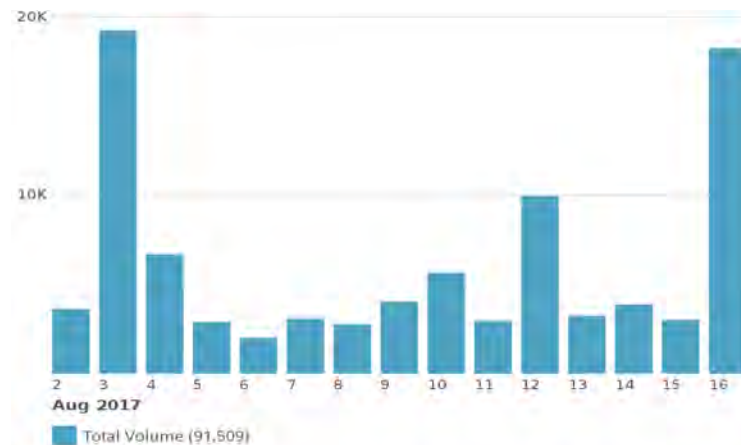
Volume surged with the President's post on his signing of the new GI Bill and as users reacted to Secretary Shulkin's remarks on Charlottesville.

## Key Points

- President Trump garnered over 4.6k RTs of his [post](#) marking the signing of the Harry W. Colmery Veterans Educational Assistance Act of 2017 with Secretary Shulkin in attendance. This tweet alone constituted just under a third of period volume.
- Secretary Shulkin's own [tweet](#) about the signing was his account's top post of the day with 140+ RTs and was the primary driver of #ForeverGIBill (190+), which was the second most-popular hashtag.
- As with traditional media, VA messaging on the GI Bill signing was overtaken by reactions to Secretary Shulkin's statements expressing outrage at the actions of Nazis and white supremacists. Five of the top ten retweeted posts referenced these remarks, with several citing a specific quote from Shulkin: "It is a dishonor to our country's veterans to allow the Nazis and the white supremacists to go unchallenged." While secondary activity included much supportive content, there was a notable theme of criticism in users' reactions that faulted the Secretary for failing to resign in protest.
- YouTube videos tended to combine the GI Bill signing with the Secretary's remarks on white nationalism by featuring the entire White House briefing on the GI Bill. The [most popular](#) of these gained 7.6k views. Additionally, these clips were often embedded in tweets focusing on Shulkin's "dishonor" quote.
- On Facebook, VBA sustained its trend of posts with elevated user engagement, with one linking to coverage [of Amazon.com's plans](#) to sell MREs garnering 440+ reactions. The main VA page reversed its trend of lower user engagement during the period with a post on the [75th anniversary](#) of the 101st Airborne Division, which saw 840+ reactions.

## Twitter and Facebook Volume:

2 August – 16 August



## Notable Social Media Items

Platform	Item	Relevance
Twitter	Topic: President signs "Forever" GI Bill	31% of Volume
Twitter	Topic: Secretary Shulkin "outraged" by Nazis and white supremacists	28% of Volume
YouTube	<a href="#">Golden State Times: Sec. Shulkin on H.R. 3218</a>	7.6k Views
Facebook	<a href="#">75th Anniversary of 101st Airborne division</a>	840+ Reactions, 220+ Shares

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## CASE RECORDS of the MASSACHUSETTS GENERAL HOSPITAL

Founded by Richard C. Cabot  
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## Case 26-2017: A 63-Year-Old Woman with Fever, Hypotension, and Hypoxemia

Alyssa R. Letourneau, M.D., M.P.H., Melissa C. Price, M.D.,  
 and Marwan M. Azar, M.D.

## PRESENTATION OF CASE

From the Departments of Medicine (A.R.L.), Radiology (M.C.P.), and Pathology (M.M.A.), Massachusetts General Hospital, and the Departments of Medicine (A.R.L.), Radiology (M.C.P.), and Pathology (M.M.A.), Harvard Medical School — both in Boston.

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*Dr. Robert H. Goldstein* (Medicine): A 63-year-old woman was admitted to the intensive care unit (ICU) of this hospital because of fever, hypotension, and hypoxemia.

Five months before the current admission, weakness of the proximal muscles of the arms and dyspnea on exertion developed in the patient. One month later, she was admitted to this hospital with worsening symptoms. Follicular erythematous papules were present on the lateral aspect of both hips, and the blood creatine kinase level was 1856 U per liter (reference range, 40 to 150).

A skin biopsy of the lesions on the lateral hips revealed interface dermatitis. A diagnosis of dermatomyositis was made. An interferon- $\gamma$  release assay for *Mycobacterium tuberculosis* was negative, and treatment with prednisone and azathioprine was initiated, along with trimethoprim-sulfamethoxazole for prophylaxis against *Pneumocystis jirovecii* pneumonia. An extensive evaluation for cancer — including mammography, computed tomography (CT) of the abdomen and pelvis, transvaginal ultrasonography, colonoscopy, and a Papanicolaou smear — was unrevealing. After the initiation of prednisone and azathioprine therapy, the blood creatine kinase level decreased to 683 U per liter, and the patient had a temporary mild increase in strength.

Despite the initial improvement of the patient's symptoms, the proximal muscle weakness gradually worsened and the blood creatine kinase level increased during the next several weeks. Dyspnea on exertion progressed, and when the patient was chewing, she noted fatigue in the muscles of her jaw and neck. Three months before the current admission, the patient was evaluated by her rheumatologist and reported severe dyspnea at rest. She was readmitted to this hospital for further evaluation, and additional imaging studies were obtained.

*Dr. Melissa C. Price*: CT of the chest was performed during expiration and after the administration of intravenous contrast material. Bilateral ground-glass opacities

in a mosaic distribution were present, and there was no consolidation (Fig. 1).

*Dr. Goldstein:* To further assess the worsening dyspnea on exertion and the abnormalities seen on imaging studies of the chest, pulmonary-function testing was performed. The forced expiratory volume in one second (FEV<sub>1</sub>), forced vital capacity (FVC), and ratio of FEV<sub>1</sub> to FVC were normal, as were the total lung capacity, carbon monoxide diffusing capacity, and maximal respiratory muscle strength.

The patient reported difficulty swallowing, and a diagnosis of aspiration was considered. A video swallow study showed only mild oropharyngeal dysphagia and no evidence of aspiration.

Because the patient had ongoing proximal muscle weakness despite treatment for dermatomyositis, a diagnosis of glucocorticoid-induced myopathy was considered and additional testing was performed. Needle electromyography revealed abnormal spontaneous activity that was suggestive of ongoing muscle injury in the left deltoid and left vastus lateralis muscles, and magnetic resonance imaging of the left leg revealed extensive muscle edema and enhancement that were consistent with myositis, as well as focal nonenhancing areas that were suggestive of necrosis.

Despite treatment with high-dose methylprednisolone and intravenous immune globulin (IVIG), the proximal muscle weakness and dyspnea persisted. Treatment with rituximab was initiated. The proximal muscle weakness and dyspnea diminished, and on hospital day 10, the patient was discharged; prednisone and azathioprine were continued. Three weeks later, she was evaluated by her rheumatologist and reported improvement in her weakness and dyspnea; the dose of prednisone was tapered from 60 mg to 40 mg daily.

One month before the current admission, dysphagia increased and new weakness of the distal muscles of the arms developed in the patient. Repeat electromyography of the arms revealed persistent myopathy in the proximal muscles and new myopathy in the distal muscles. A muscle biopsy was performed. Pathological evaluation of a biopsy specimen of the right quadriceps muscle revealed an active inflammatory myopathy, and electron microscopy revealed tubuloreticular inclusions in endothelial cells, a

finding supportive of the diagnosis of dermatomyositis. The dose of prednisone was increased, and the patient was again treated with IVIG.

On the day of the current admission to this hospital, the patient was seen in the rheumatology clinic and then referred to the emergency department for evaluation because of a 2-day history of increasing fatigue, chills, night sweats, increased dysphagia, and a new productive cough. The patient reported no dysuria, diarrhea, abdominal pain, or headache. She had a history of glaucoma and hypothyroidism. Ten years earlier, she had been treated with a 6-month course of isoniazid for latent tuberculosis, which had been diagnosed with the use of tuberculin skin testing. In addition to prednisone and azathioprine, her medications included levothyroxine, liothyronine, and a multivitamin. She had received the

A

B

**Figure 1. CT Scan of the Chest Obtained 3 Months before Admission.**

Axial and coronal images (Panels A and B, respectively), obtained after the administration of contrast material, show mosaic attenuation of the lung parenchyma and no consolidation.



last infusion of rituximab 10 weeks earlier. Her mother had myasthenia gravis, and multiple family members had had lung cancer. She worked as a health care provider, lived in New England, and had traveled to California but not outside the United States.

On examination, the temperature was 39.3°C, the blood pressure 85/47 mm Hg, the pulse 90 beats per minute, the respiratory rate 32 breaths per minute, and the oxygen saturation 87% while the patient was breathing ambient air. Supplemental oxygen was delivered through a nasal cannula at a rate of 3 to 6 liters per minute, with adjustment to keep the oxygen saturation above 93%. The patient was awake and alert but appeared generally unwell. The first and second heart sounds were normal, without murmurs, and there was no jugular venous distention. Crackles were present in the lower lung fields. Bowel sounds were present, and the abdomen was soft, nondistended, and nontender on palpation. The liver and spleen were not palpable. The arms and legs had no edema, and muscle bulk was diffusely decreased. Strength was symmetric and graded as 4 out of 5 in the proximal and distal muscles of the arms, 4 out of 5 in the proximal muscles of the legs, and 5 out of 5 in the distal muscles of the legs. Deep-tendon reflexes were diffusely hypoactive in the arms and knees and normal at the ankles. Cultures of urine and blood had no growth. Testing of a nasal swab for influenza A and B nucleic acids was negative. A screening test for human immunodeficiency virus (HIV) type 1 p24 antigen and HIV type 1 and type 2 antibodies was negative; other laboratory test results are shown in Table 1. A chest radiograph showed a patchy linear opacity at the base of the left lung. Intravenous fluids, high-dose methylprednisolone, vancomycin, and cefepime were administered, and the patient was admitted to the ICU while she received a continuous infusion of norepinephrine. Azathioprine was discontinued, and atovaquone was substituted for trimethoprim-sulfamethoxazole.

The blood pressure improved. Norepinephrine and methylprednisolone were discontinued, prednisone was resumed, and the patient was transferred to the medical unit. Vancomycin and cefepime were continued. The patient's need for

supplemental oxygen to maintain 93% saturation varied from 1 liter delivered through a nasal cannula to 10 liters delivered through a face tent. Additional imaging studies were obtained.

*Dr. Price:* CT of the chest, performed without the administration of intravenous contrast material, revealed new consolidations in the dependent portion of the bilateral lower lobes and inferior lingula. In addition, new interlobular septal thickening, bilateral ground-glass opacities, and trace bilateral pleural effusions were present. Subpleural reticulations were seen in the lower lobes. There was no intrathoracic lymphadenopathy (Fig. 2).

*Dr. Goldstein:* A repeat video swallow study was obtained on hospital day 8 because of concerns about possible aspiration pneumonia. There was moderate oropharyngeal dysphagia and intermittent trace aspiration.

The patient had no fever for 3 days, but on hospital day 5, the temperature rose to 39.6°C. During the next 3 days, high temperatures persisted despite continued treatment with vancomycin and cefepime. Cultures of urine and blood were sterile; other laboratory test results are shown in Table 1. Diagnostic tests were performed, and a diagnosis was made.

#### DIFFERENTIAL DIAGNOSIS

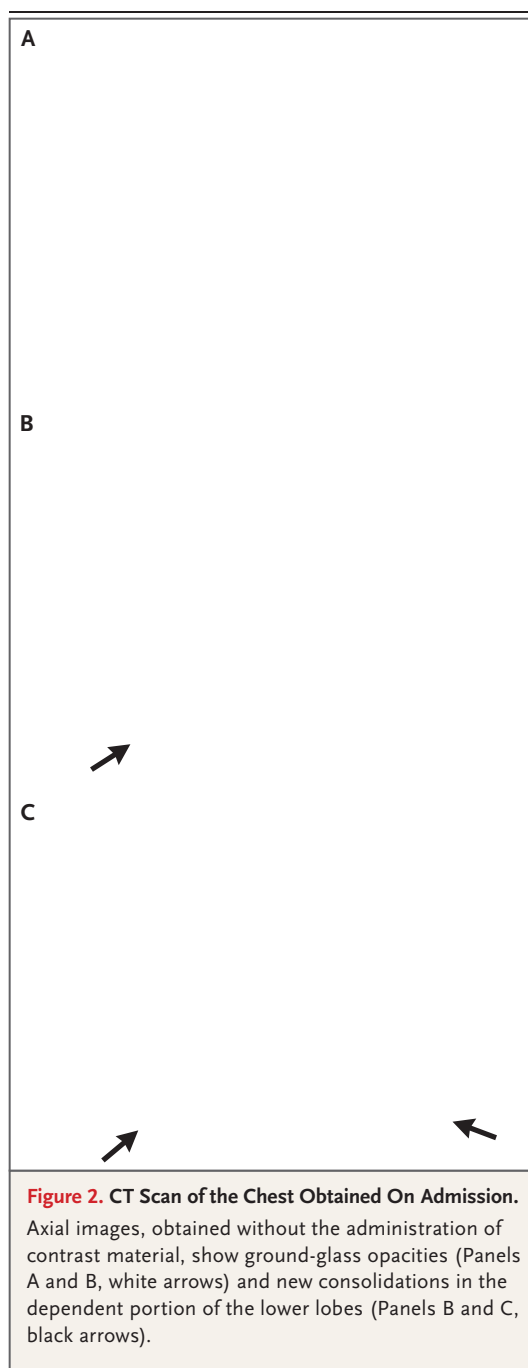
*Dr. Alyssa R. Letourneau:* This 63-year-old woman was admitted to the ICU of this hospital with fever, hypotension, and hypoxemia. Her condition initially improved after the administration of high-dose glucocorticoid therapy and broad-spectrum antibiotic agents, but she subsequently had worsening pancytopenia and recurrent fever. In developing a differential diagnosis in this case, it is important to consider this patient's current presentation in the context of the immunosuppressive medications she had received for the treatment of severe dermatomyositis.<sup>1,2</sup> She had received azathioprine for 4 months, varying doses of glucocorticoids for several months, and one dose of rituximab 10 weeks before her current admission. In constructing a differential diagnosis, I will take into account this patient's immunosuppression,<sup>1,2</sup> history of treated latent tuberculosis, treatment with trimethoprim-

**Table 1. Laboratory Data.\***

Variable	Reference Range, Adults†	On Presentation	Hospital Day 5
Hematocrit (%)	36–46	31	27
Hemoglobin (g/dl)	12–16	10.1	8.7
White-cell count (per mm <sup>3</sup> )	4500–11,000	1580	900
Differential count (%)			
Neutrophils	40–70	82.9	67.7
Lymphocytes	22–44	12.7	18.2
Monocytes	4–11	3.8	8.1
Eosinophils	0–8	0	2.0
Basophils	0–3	0	1.0
Platelet count (per mm <sup>3</sup> )	150,000–400,000	103,000	107,000
Red-cell count (per mm <sup>3</sup> )	4,000,000–5,200,000	3,550,000	3,100,000
Reticulocyte count (%)	0.5–2.5	2.2	NA
Mean corpuscular volume (fl)	80–100	86.8	87.7
Mean corpuscular hemoglobin (pg)	26–34	28.5	28.1
Mean corpuscular hemoglobin concentration (g/dl)	31–37	32.8	32.0
Prothrombin time (sec)	11.5–14.5	14.7	NA
Prothrombin-time international normalized ratio	0.9–1.1	1.2	NA
Activated partial-thromboplastin time (sec)	22–35	35	NA
Sodium (mmol/liter)	135–145	130	134
Potassium (mmol/liter)	3.5–5.0	4.0	3.5
Chloride (mmol/liter)	98–108	96	99
Carbon dioxide (mmol/liter)	23–32	23	25
Calcium (mg/dl)	8.5–10.5	8.1	7.8
Glucose (mg/dl)	70–110	100	92
Urea nitrogen (mg/dl)	8–25	18	13
Creatinine (mg/dl)	0.6–1.5	0.8	0.6
Total protein (g/dl)	6.0–8.3	5.9	5.5
Albumin (g/dl)	3.4–5.0	3.0	2.6
Alkaline phosphatase (U/liter)	30–100	95	86
Total bilirubin (mg/dl)	0–1.0	0.6	0.5
Alanine aminotransferase (U/liter)	7–33	27	27
Aspartate aminotransferase (U/liter)	9–32	69	68

\* NA denotes not available. To convert the values for calcium to millimoles per liter, multiply by 0.250. To convert the values for glucose to millimoles per liter, multiply by 0.5551. To convert the values for urea nitrogen to millimoles per liter, multiply by 0.357. To convert the values for creatinine to micromoles per liter, multiply by 88.4. To convert the values for bilirubin to micromoles per liter, multiply by 17.1.

† Reference values are affected by many variables, including the patient population and the laboratory methods used. The ranges used at Massachusetts General Hospital are age-adjusted for patients who are not pregnant and do not have medical conditions that could affect the results. They may therefore not be appropriate for all patients.



sulfamethoxazole, and clinical deterioration despite broad-spectrum antibiotic therapy.

#### TUBERCULOSIS

Does this patient have tuberculosis? Active infection with *M. tuberculosis* has a variable presentation and can be difficult to diagnose. This patient

had been treated for latent tuberculosis 10 years before the current admission. Screening and treatment for latent tuberculosis in immunocompetent patients before they receive immunosuppressive medications decreases the risk of reactivation associated with the use of such medications. Screening for latent tuberculosis can be performed with a Mantoux tuberculin skin test or an interferon- $\gamma$  release assay. Both of these tests rely on a functioning immune system and may not be reliable in immunosuppressed patients; thus, screening before the administration of immunosuppressive medications is important.

This patient received appropriate treatment for latent tuberculosis with a 6-month course of isoniazid, which is 65% effective in preventing the reactivation of tuberculosis. Reactivation can be seen in patients who have received therapy with glucocorticoids or rituximab (such as this patient) but is more common in persons who have received therapy with a tumor necrosis factor  $\alpha$  inhibitor.<sup>3,4</sup> This patient had a negative interferon- $\gamma$  release assay before she began to receive immunosuppressive medications, but I suspect this was a false negative test, since the interferon- $\gamma$  release assay should be positive for life in a person with a history of latent tuberculosis. If her current presentation were due to tuberculosis, I would expect her to have more prominent sweats and weight loss. I would also expect the imaging studies of the chest to show a miliary pattern, cavitary lesions, or nodules rather than ground-glass opacities. On the basis of her clinical presentation, the findings on imaging studies, and her history of treatment with isoniazid, I think reactivation of tuberculosis is unlikely.

#### *P. jirovecii* PNEUMONIA

Could this patient have *P. jirovecii* pneumonia? Patients with *P. jirovecii* pneumonia typically present with dry cough, fever, progressive dyspnea, and ground-glass opacities on imaging studies of the chest. Risk factors for *P. jirovecii* pneumonia include advanced HIV type 1 infection, allogeneic and autologous stem-cell transplantation, acute lymphocytic leukemia, treatment with alemtuzumab, and administration of high-dose glucocorticoid therapy for longer than 1 month. This patient had received prednisone at varying doses for several months; this is a clinically significant

risk factor for the development of *P. jirovecii* pneumonia. However, she had reportedly received trimethoprim–sulfamethoxazole prophylaxis, which substantially decreases the likelihood that this infection would develop.

#### BABESIOSIS

Although I do not know the time of year that this patient presented to the hospital, she lives in New England and is therefore at risk for a tickborne disease such as babesiosis. Patients with babesiosis typically have fever, influenza-like illness, and sweats, along with hemolytic anemia, leukopenia, thrombocytopenia, and elevated liver aminotransferase levels. Some patients appear more ill and have a dry cough and shortness of breath; in patients with severe disease, multiorgan system failure can occur. Patients who are treated with rituximab are at an increased risk for severe babesiosis.<sup>5</sup> This patient's condition initially improved after she was admitted to the hospital and received an antibiotic regimen that included atovaquone, which was substituted for trimethoprim–sulfamethoxazole in the context of pancytopenia. Atovaquone has activity against *Babesia microti*, but effective therapy for babesiosis typically requires a combination of atovaquone and azithromycin. This patient's presentation is unlikely to be explained by babesiosis, since there is no mention of exposure to ticks in her history and her condition appeared to improve after treatment with atovaquone monotherapy.

#### FUNGAL INFECTIONS

This immunosuppressed patient is at risk for invasive fungal infections, including endemic mycoses (e.g., histoplasmosis, blastomycosis, and coccidioidomycosis) and *Aspergillus fumigatus* infection. Endemic mycoses can cause pancytopenia in the context of systemic disease. Although this patient has no history of travel to a region in which histoplasma or blastomyces is endemic, she may have had exposure to coccidioides. However, histoplasmosis and blastomycosis typically cause nodular pulmonary lesions and coccidioidomycosis usually causes cavitory lesions, and these lesions were not present on imaging studies of the chest in this patient. Aspergillosis, which also tends to cause nodular or cavitory disease, is seen primarily in patients with hematologic

cancer, particularly those with prolonged neutropenia.

#### VIRAL INFECTIONS

Many viruses could cause this patient's clinical disease; however, I will focus on common viruses that can potentially be identified through culture or molecular techniques. Viral respiratory pathogens are an important consideration in this patient with fever and ground-glass opacities on imaging studies of the chest. Testing for influenza A and B nucleic acids was negative. I would also recommend testing for respiratory syncytial virus, parainfluenza virus, adenovirus, and human metapneumovirus, because these viruses can cause severe disease in immunosuppressed patients. Of these viruses, adenovirus would be the most likely to explain this patient's fever, ground-glass opacities, and elevated aspartate aminotransferase level. The absence of associated gastrointestinal symptoms and conjunctivitis argues against a diagnosis of adenovirus because these findings are classically associated with this disease. However, given the many serotypes of adenovirus and the broad range of associated clinical syndromes, diagnostic testing for adenovirus should be performed.

After initial infection, human herpesviruses enter a latency phase and can reactivate during immunosuppression. Human herpesvirus types 1 and 2 are common and typically cause vesicular lesions of the mouth or genitalia. They can also cause disseminated disease, including meningitis, pneumonitis, pneumonia, and hepatitis. Varicella–zoster virus is best known for causing a primary infection associated with diffuse pruritic vesicular lesions. It can also cause disseminated disease similar to that caused by human herpesvirus types 1 and 2. Disseminated varicella–zoster virus is more common in patients who have HIV infection or have undergone stem-cell transplantation than in other immunosuppressed hosts. This patient does not have the rash that is typically associated with disseminated infection with human herpesvirus type 1 or 2 or varicella–zoster virus, and these viruses are less likely than other human herpesviruses, such as cytomegalovirus (CMV), to cause pancytopenia.

Similar to patients with Epstein–Barr virus infection, patients with CMV infection have fever and malaise; however, patients with CMV infec-

tion typically do not have tonsillitis or pharyngitis. In immunosuppressed patients, primary CMV infection and reactivation can result in a similar presentation. This patient has several risk factors for the reactivation of CMV infection, including prolonged use of glucocorticoids and treatment with rituximab.<sup>6</sup> CMV can affect every organ system, and common manifestations include anemia, thrombocytopenia, hepatitis, retinitis, pneumonitis, and colitis or gastritis with ulcerative lesions. Patients with CMV pneumonitis usually present with cough, fever, and ground-glass opacities on imaging studies of the chest.<sup>7</sup> This patient's initial presentation may have been due to aspiration pneumonia, and on the basis of her clinical course, I suspect that CMV infection developed during her hospitalization, which was complicated by pneumonitis and pancytopenia. In order to confirm this diagnosis, a lung biopsy should be performed; however, I would first obtain blood to test for CMV nucleic acids and obtain bronchoalveolar-lavage fluid to perform a shell-vial culture for CMV. Positive results on these tests would be highly suggestive of CMV infection complicated by pneumonitis.

*Dr. Meridale V. Baggett (Medicine):* Dr. Goldstein, what was your impression when you evaluated this patient?

*Dr. Goldstein:* The infectious disease consult service was asked to evaluate this patient because she had persistent hypoxemia and fever despite the administration of broad-spectrum antibiotics. We considered the possibility of interstitial lung disease in the context of her underlying dermatomyositis. However, in view of her substantial immunosuppression, we were most concerned about an underlying infectious process. We recommended bronchoscopy to investigate for bacterial, atypical bacterial, mycobacterial, fungal, and viral pathogens. However, given the presence of ground-glass opacities, hypoxemia, worsening pancytopenia, and persistent fevers despite the administration of broad-spectrum antibiotics, we thought the most likely diagnosis was CMV pneumonitis.

#### CLINICAL DIAGNOSIS

Cytomegalovirus pneumonitis.

#### DR. ALYSSA R. LETOURNEAU'S DIAGNOSIS

Cytomegalovirus infection complicated by pneumonitis and pancytopenia.

#### PATHOLOGICAL DISCUSSION

*Dr. Marwan M. Azar:* The diagnostic test in this case was a real-time polymerase-chain-reaction (PCR) assay for CMV DNA quantitation in whole blood. A blood sample was collected on hospital day 4 for measurement of the CMV DNA viral load; the result, which was available approximately 48 hours later, was 1,280,000 IU per milliliter (range of detection, 137 to 9,100,000). The CMV DNA viral load must be interpreted in the context of all relevant clinical and laboratory findings. High-level CMV viremia has been associated with both severe and tissue-invasive CMV disease.<sup>8</sup> In this immunocompromised patient who presented with a clinical syndrome of pneumonia, high-level CMV viremia is highly suggestive of CMV pneumonitis.

In addition to molecular testing, a shell-vial culture of bronchoalveolar-lavage fluid for CMV was performed on hospital day 6. The shell-vial culture is performed with the use of an indirect immunofluorescence technique; it can detect the immediate early antigen of CMV before the development of detectable cytopathic effects. In this case, homogeneous green staining of nuclei was evident at 16 hours and 48 hours after inoculation, a finding that indicates the presence of CMV (Fig. 3).

Molecular methods are rapid and highly sensitive for the detection of CMV replication in blood specimens.<sup>9</sup> Shell-vial cultures are less sensitive but highly specific, and when they are performed on specimens of bronchoalveolar-lavage fluid in the clinical context of pneumonia, they may provide supplemental evidence to support the diagnosis of CMV pneumonitis. It is important to note that, depending on the clinical scenario, both low-level viremia that is detected by means of PCR assay and a positive shell-vial culture may indicate viral shedding rather than active disease. Although histopathological confirmation of tissue-invasive CMV disease is standard for diagnosis, the microbiologic



findings of high-level CMV viremia and a positive shell-vial culture, taken together with this patient's clinical syndrome, are consistent with the diagnosis of CMV pneumonitis in this case.

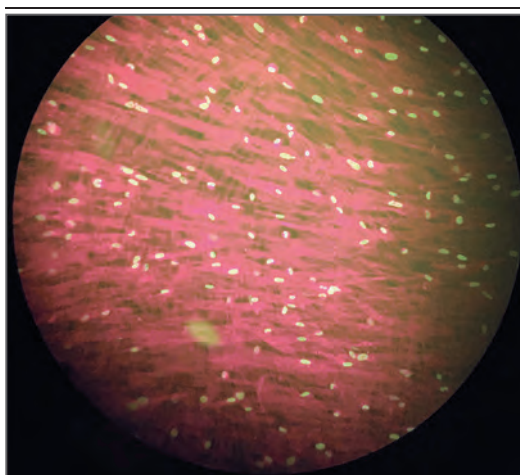
#### DISCUSSION OF MANAGEMENT

*Dr. Goldstein:* Once the diagnosis of CMV pneumonitis was established, the patient was treated with intravenous ganciclovir, which was transitioned to oral valganciclovir on discharge. After discharge, we monitored the efficacy of antiviral therapy by measuring the CMV DNA viral load weekly. When the patient had an adequate clinical and virologic response to treatment, we transitioned her treatment to suppressive antiviral therapy with lower-dose valganciclovir. In addition, we worked with the rheumatology team to taper her immunosuppressive medications in an effort to prevent further complications. Since she received the diagnosis of CMV, the patient has not had recurrent disease.

*Dr. Baggett:* It is my pleasure to invite the patient to tell us about her experience with this illness.

*The Patient:* I was a very healthy woman, frequently climbing three flights of stairs. At first, my symptoms were very subtle: I couldn't lift my left leg to get in the car, and then I was a little short of breath. I encourage you to ask your patients about their symptoms and really listen to everything they are saying. In and of themselves, my symptoms might not have seemed very important, but in retrospect, once I was diagnosed, they meant quite a bit. When I first had severe upper-body muscle weakness, I thought it was because I hadn't been exercising, but then all of a sudden things started going downhill really quickly. Showering was hard. Lifting my arms was difficult. It got to the point that I couldn't even raise my arms up to dress myself. I saw a rheumatologist and he asked me if I had a rash on my hips. At first I said no, but then I looked and, yes, I did have a rash on my hips. They call it the holster sign. The rash was biopsied, and I was diagnosed with dermatomyositis.

How has the diagnosis of dermatomyositis affected me? I went from being a very healthy woman to someone receiving long-term disability, with numerous appointments, hospitaliza-



**Figure 3.** Results of a Shell-Vial Culture for Cytomegalovirus.

The nuclear staining of infected human fibroblast cells (in light green) indicates the presence of immediate early antigen of cytomegalovirus, a marker of active cytomegalovirus replication.

tions, tests, and procedures. It has been a roller coaster ride, in terms of wondering how it's going to go. It was difficult for me because I didn't know whether I was going to get well. In the beginning, I could not get in or out of bed — somebody had to pull my feet up in the bed and pull me up out of the bed. I couldn't bathe myself. I could barely feed myself. I had been a very independent person and I found myself in this very dependent state, which bothered me to no end. But now my muscle strength is better, so I'm able to function at home by myself. I can do laundry and cook. Going up the stairs takes some time, and I have to stop and take rests. I'm functioning, albeit not as well as before.

#### FINAL DIAGNOSIS

Cytomegalovirus pneumonitis.

This case was presented at the Harvard Medical School continuing medical education course "Primary Care Internal Medicine," directed by John D. Goodson, M.D.

No potential conflict of interest relevant to this article was reported.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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## REVIEW ARTICLE

Dan L. Longo, M.D., *Editor*Use of Liver Imaging and Biopsy  
in Clinical Practice

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LIVER BIOPSIES ARE TRADITIONALLY PERFORMED TO DETERMINE THE cause and stage of liver disease, as well as to inform treatment decisions and determine prognosis. In 2001, Bravo et al. observed that “liver biopsy is usually the most specific test to assess the nature and severity of liver diseases.”<sup>1</sup> During the past 16 years, however, the clinical use of liver biopsies has undergone a profound transformation. Validated alternatives to liver biopsy have proliferated, spurred by concerns about the costs of biopsy and the risk of complications. Furthermore, research has brought a new understanding of the limitations of liver biopsy. In this review, we discuss the role of liver biopsy in the current era, as well as the accuracy of noninvasive evaluations and their use in clinical practice for determining the cause of liver disease and focal liver lesions and for detecting advanced fibrosis and cirrhosis.

## LIVER BIOPSY

## PROCEDURE, INDICATIONS, AND INTERPRETATION

Liver biopsies are usually performed percutaneously but can instead be performed through a laparoscopic, transjugular, or endoscopic route.<sup>2</sup> The specific approach selected depends on chest-wall thickness (since the percutaneous route may be problematic in obese patients) and status with respect to thrombocytopenia or coagulopathy. A typical liver biopsy samples one fifty-thousandth of the liver volume.<sup>1</sup> Histologic assessment requires clinicopathological correlation. Pathologists systematically survey and report on the degree and pattern of inflammation, steatosis, and fibrosis, as well as other notable features such as cellular inclusions, and clinicians provide the clinical context that informs the histologic interpretation.

Most histologic features are not discrete but are part of a continuum. To facilitate comparisons across studies and to evaluate changes during therapeutic trials, pathologists developed categorical scoring systems to grade inflammation, steatosis, and fibrosis.<sup>3</sup> Though staging schema vary slightly according to the underlying disease, the system most often used for fibrosis staging in patients with viral hepatitis ranges from F0 to F4 as follows: no fibrosis (F0), portal fibrosis without septa (F1), portal fibrosis with few septa (F2), bridging septa between central and portal veins (F3), and cirrhosis (F4).<sup>4</sup> Liver biopsies are also used to determine or confirm the cause of the liver disease. The pattern of inflammation can aid in the diagnosis of autoimmune hepatitis (plasma-cell and lymphocytic infiltration in portal tracts and the connective tissue between portal tracts and septa), primary biliary cholangitis (periductular inflammation, or “florid-duct lesions”), and primary sclerosing cholangitis (periductular inflammation and fibrosis, or “onion skin”). Similarly, patterns of cellular proliferation help discern the cause of focal liver lesions.

**LIMITATIONS**

Much of the interest in noninvasive evaluation of liver disease comes from the risk of complications with liver biopsy and the technical limitations of the procedure. There are several limitations. First, sampling error is common, and many liver diseases do not affect the liver uniformly.<sup>3,5-7</sup> In a study of laparoscopic biopsy samples taken simultaneously from the right and left lobes in 124 patients with hepatitis C virus (HCV), the biopsy findings in 14.5% of the patients were interpreted as cirrhosis in one lobe but as F3 fibrosis in the other lobe.<sup>7</sup> In a sentinel study involving 51 patients with nonalcoholic fatty liver disease in whom two biopsy samples were obtained on the same day, 35% of the patients with F3 fibrosis in one sample had F0 or F1 fibrosis in the other.<sup>6</sup> Complicating matters further, both diagnostic accuracy and disease staging depend on specimen size. Small biopsy samples may be nondiagnostic or may not reveal cirrhosis.<sup>8</sup> Analyzing images of more than 27,000 “virtual” biopsy samples of variable length, Poynard and colleagues found that accuracy was maximized by assessing specimens that were at least 3 cm in length.<sup>9</sup> Such large specimens are rarely obtained in practice. In a clinical trial involving 513 patients, 36% of biopsy samples were less than 1.5 cm in length.<sup>5</sup> Similarly, a single biopsy sample has a negative predictive value no greater than 74% for the presence of steatohepatitis in patients with nonalcoholic fatty liver disease.<sup>6</sup>

Second, biopsy interpretation is subjective. Even among the pathologists involved with the development of staging criteria, the interobserver and intraobserver concordance for fibrosis stage was 78% and 75%, respectively, but concordance for inflammatory activity and fat burden was less than 50%.<sup>3</sup>

Third, biopsies are associated with complications, including pain (in 30 to 50% of patients),<sup>10</sup> serious bleeding (0.6%),<sup>11</sup> injury to other organs (0.08%),<sup>12</sup> and in rare cases, death (up to 0.1%).<sup>2</sup> For these reasons, many patients refuse to undergo liver biopsy.<sup>13</sup>

Fourth, biopsies are costly. Each biopsy involves an expert gastroenterologist or radiologist and a pathologist and must be performed in a facility with adequate periprocedural monitoring by nurses. Consequently, the average direct cost of a percutaneous liver biopsy is \$1,558 (in 2016 U.S. dollars),<sup>14,15</sup> which rises substantially for

biopsies performed by the transjugular route. There are also unmeasured indirect costs, including lost work productivity for both patients and their caretakers.

**NONINVASIVE FIBROSIS ASSESSMENT**

The staging of liver disease is essential for risk stratification with respect to complications and death.<sup>16-18</sup> Patients with advanced fibrosis (F3 or F4) have the highest risk of portal hypertensive complications such as variceal hemorrhage, liver failure, and (with specific exceptions) liver cancer.<sup>5,16-19</sup> Unfortunately, the medical history and physical examination do not provide a sufficient basis for detecting advanced fibrosis.<sup>20,21</sup> Classic signs — jaundice, ascites, splenomegaly, and encephalopathy — are absent in early cirrhosis. Similarly, patients with cirrhosis may have normal results of liver chemical profiles.<sup>21</sup>

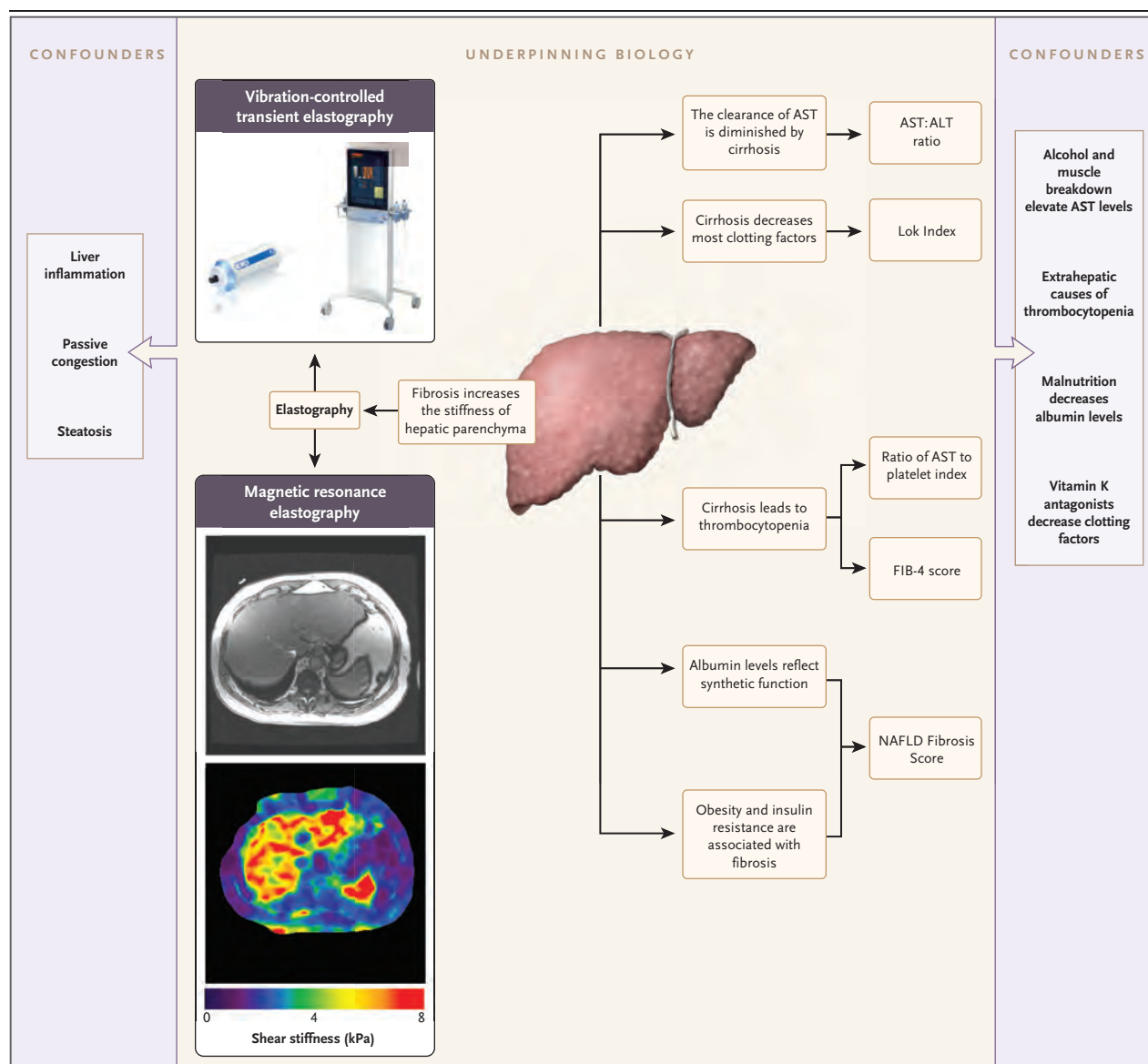
Several noninvasive methods for the assessment of liver fibrosis have been developed and are widely used. Unlike a biopsy, these methods cannot differentiate the stages of fibrosis but are accurate in discriminating early from advanced fibrosis<sup>22</sup> (Fig. 1 and Table 1).

**INDIRECT AND DIRECT SEROLOGIC MARKERS**

Indirect serologic markers of fibrosis generally reflect the secondary effects of liver injury. For example, among patients with chronic liver disease due to viral hepatitis or other nonalcoholic causes, aspartate aminotransferase levels exceed alanine aminotransferase levels when cirrhosis develops, probably as a result of decreased clearance of aspartate aminotransferase and decreased production of alanine aminotransferase.<sup>37</sup> Thus, the aspartate aminotransferase level and the ratio of aspartate aminotransferase to alanine aminotransferase are included in many indirect indexes of liver fibrosis<sup>25,28,37,38</sup> (Fig. 1). Thrombocytopenia, however, is the earliest indicator of cirrhosis among routine blood tests, capturing the results of multiple processes associated with advanced liver disease, including, at least, diminished liver function (thrombopoietin underproduction) and portal hypertension (splenic sequestration).<sup>21,39</sup>

Several risk scores use the presence of thrombocytopenia to predict advanced fibrosis or cirrhosis (Fig. 1). Other indexes incorporate proteins that are produced less abundantly by the injured liver (e.g., clotting factors, haptoglobin,





**Figure 1. Noninvasive Assessment of Liver Fibrosis.**

Imaging techniques and biomarker measurements used to assess the risk of cirrhosis are shown, including the biologic rationale for their use and factors that can confound the results. The ratio of aspartate aminotransferase (AST) to platelet index is calculated as follows:  $(AST \div \text{upper limit of the normal range}) \div \text{platelet count}$ . The Fibrosis-4 (FIB-4) score is calculated as  $(\text{age} \times AST) \div (\text{platelet count} \times \sqrt{ALT})$ . The Lok Index is calculated as follows:  $\log \text{odds} = -5.56 - 0.0089 \times \text{platelet} + 1.26 \times \text{AST:ALT ratio} + 5.27 \times \text{INR}$ . The NAFLD Fibrosis Score is calculated as follows:  $-1.675 + 0.037 \times \text{age} + 0.094 \times \text{BMI} + 1.13 \times \text{IR or diabetes (yes = 1, no = 0)} + 0.99 \times \text{AST:ALT ratio} - 0.013 \times \text{platelet count} - 0.66 \times \text{albumin}$ . ALT denotes alanine aminotransferase, BMI body-mass index (the weight in kilograms divided by the square of the height in meters), INR international normalized ratio, IR insulin resistance, and NAFLD nonalcoholic fatty liver disease.

and apolipoprotein A).<sup>38,40,41</sup> The NAFLD [Non-alcoholic Fatty Liver Disease] Fibrosis Score<sup>31</sup> also includes body-mass index and the status with respect to diabetes or impaired fasting glucose, markers that correlate with advanced fibrosis in nonalcoholic fatty liver disease. Indexes

based on routinely available laboratory tests often do not incur added costs and can be used in resource-limited settings.<sup>42</sup> However, there are pitfalls — namely, a false conclusion that thrombocytopenia is due to cirrhosis rather than hematologic causes or that increased aspartate amino-

**Table 1. Noninvasive Risk Stratification for Various Liver Diseases.\***

		Cutoffs for Advanced Fibrosis	Sensitivity	Specificity	Negative Likelihood Ratio	Positive Likelihood Ratio	Probability of Advanced Fibrosis (F3 or F4) after a Negative vs. a Positive Test†
Test	Study		%	%			%
Hepatitis C							
AST:platelet ratio index	Lin et al. <sup>25</sup>	>1.0	61	64	0.61	1.7	38 vs. 63
		>1.5	50	87	0.57	3.8	36 vs. 79
FIB-4 score	Vallet-Pichard et al. <sup>26</sup>	<1.45	74	80	0.32	3.7	24 vs. 80
		>3.25	38	82	0.76	2.1	43 vs. 68
VCTE	Castéra et al. <sup>27</sup>	>9.5	73	91	0.30	8.1	23 vs. 89
Hepatitis B							
FIB-4 score	Kim et al. <sup>28</sup>	<1.0	91	73	0.12	3.4	11 vs. 77
		>2.65	39	98	0.63	18.3	39 vs. 95
VCTE	Marcellin et al. <sup>29</sup>	<8.1	86	85	0.16	5.7	14 vs. 85
		>10.5	72	95	0.29	14.4	23 vs. 94
NAFLD							
FIB-4 score	Shah et al. <sup>30</sup>	<1.3	74	71	0.4	2.6	27 vs. 72
		>2.67	33	98	0.7	16.5	41 vs. 94
NAFLD Fibrosis Score	Angulo et al. <sup>31</sup>	<-1.455	77	71	0.3	2.7	24 vs. 73
		>0.676	43	96	0.6	10.8	37 vs. 91
VCTE	Tapper et al. <sup>32</sup>	>9.9	95	77	0.07	4.1	6 vs. 81
MRE	Loomba et al. <sup>33</sup>	>3.64	86	91	0.2	9.6	13 vs. 91
Cholestatic liver diseases							
VCTE for primary biliary cholangitis	Corpechot et al. <sup>34</sup>	>10.7	90	93	0.11	12.9	10 vs. 93
VCTE for primary sclerosing cholangitis	Corpechot et al. <sup>35</sup>	>9.6	93	83	0	5.5	8 vs. 85
All liver diseases							
MRE	Singh et al. <sup>36</sup>	>4.11	85	85	0.2	5.7	15 vs. 85

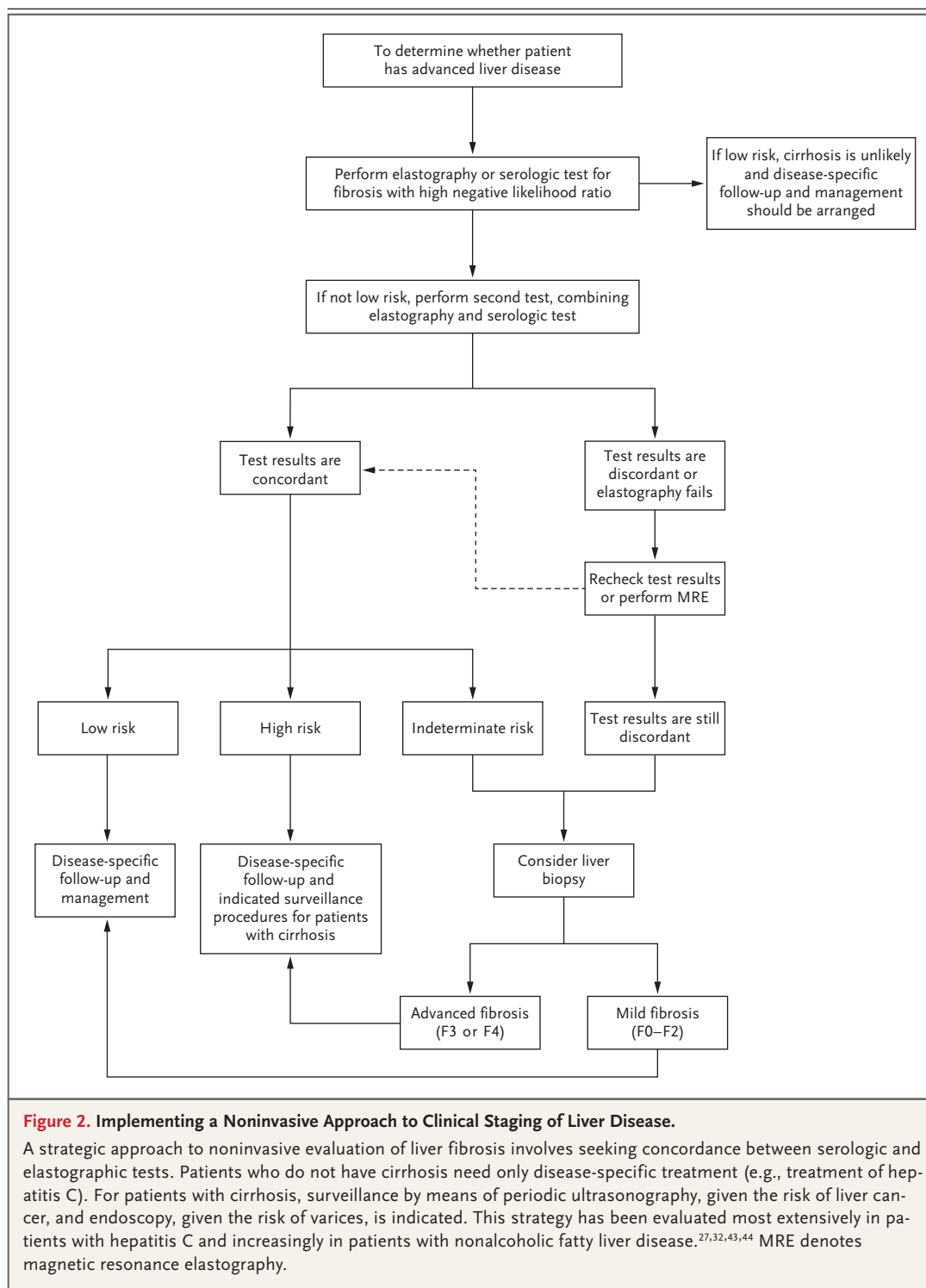
\* The specific calculations of kilopascals differ between elastographic techniques. Thus, the kilopascal calculation determined by means of vibration-controlled transient elastography (VCTE) is not equivalent to the calculation determined by means of magnetic resonance elastography (MRE).<sup>23</sup> Some tests have two cutoffs with indeterminate ranges. Cutoffs and test characteristics for assessment of the risk of cirrhosis (F4) are provided in Table S1 in the Supplementary Appendix, available with the full text of this article at NEJM.org. Cutoffs that indicate a need for antiviral therapy in patients with and those without elevated alanine aminotransferase levels may vary.<sup>24</sup> AST denotes aspartate aminotransferase, FIB-4 Fibrosis-4, and NAFLD nonalcoholic fatty liver disease.

† We applied a Bayesian calculation of post-test probability for each index, assuming a 50% pretest likelihood of advanced fibrosis (F3 or F4) for the purpose of illustration. F3 denotes bridging septa between central and portal veins, and F4 cirrhosis.

transferase levels indicate cirrhosis rather than alcohol abuse or extrahepatic factors (e.g., muscle injury). Finally, some indirect indexes have two cutoffs (to maximize sensitivity or specificity), which create gray zones of indeterminate values (Table 1). A clinical strategy for managing this possibility is discussed below and in Figure 2.

Direct measures of fibrosis assess circulating

evidence of fibrogenesis, fibrinolysis, or both. Examples include  $\alpha_2$ -macroglobulin, hyaluronic acid, N-terminal propeptide of type III procollagen, and tissue inhibitor of metalloproteinase 1. Proprietary algorithms for these assays are commercially available as FibroTest (BioPredictive) (known as FibroSure [LabCorp] in the United States), FibroMeter (Echosens), HepaScore (Quest



Diagnostics), FIBROSpect (Prometheus Laboratories), and the Enhanced Liver Fibrosis Score (Siemens Healthcare Diagnostics). These tests can have false positive results in patients with chronic inflammatory conditions, chronic renal disease, or extrahepatic causes of abnormal fibrogenesis. The assays are also costlier and less widely available than indirect measures.

#### IMAGING TESTS

Standard imaging tests can suggest the possibility of cirrhosis. Morphologic characteristics that may indicate the presence of cirrhosis include liver nodularity and an enlarged caudate lobe relative to the right lobe. A fibrotic liver may also appear “brighter” on ultrasonography than a nonfibrotic liver. Commonly available imaging techniques are not reliably accurate for diagnosing cirrhosis or ruling it out (e.g., ultrasonographic evaluation of the liver contour has a sensitivity and specificity for cirrhosis of 13 to 88% and 78 to 95%, respectively).<sup>45</sup> The sensitivity of ultrasound-based diagnoses of cirrhosis can be increased by accounting for markers of portal hypertension (e.g., increased spleen size and portal-vein diameter) or the presence of abdominal varices or ascites, but these signs are absent in early cirrhosis. Although the diagnostic test characteristics of conventional computed tomography (CT) or magnetic resonance imaging (MRI) are better (sensitivity, 48.5% to 87.9%; specificity, 55.2% to 100%), the interrater reliability of these measures among radiologists can be inadequate (kappa score, 0.12 to 0.74).<sup>46</sup>

#### ELASTOGRAPHY

Liver elastography provides more accurate assessments of advanced fibrosis than imaging tests do. There are multiple approaches to the use of this technique: vibration-controlled transient elastography, magnetic resonance elastography, acoustic radiation force–based elastography, and shear wave elastography. Of these approaches, vibration-controlled transient elastography is the most widely used worldwide. In each case, a shear wave is introduced into the liver across the chest wall by means of a probe, and wave propagation is then evaluated by a receiver in the probe, except that with magnetic resonance elastography, the wave is interpreted by the magnetic resonance scanner. The wave’s velocity is then converted into a measurement of liver stiffness,

expressed in kilopascals, which correlates with the fibrosis burden. Liver stiffness is a continuous measure that does not stage fibrosis. Cutoffs suggestive of advanced fibrosis have been proposed but vary substantially according to the technique used (i.e., kilopascal units for vibration-controlled transient elastography and for magnetic resonance elastography are not interchangeable) and the underlying liver disease; cutoffs also differ among studies of the same disease (Table 1). The use of any cutoff for liver stiffness therefore carries a degree of uncertainty.<sup>26</sup>

In general, elastography offers excellent negative likelihood ratios for advanced fibrosis but much poorer positive likelihood ratios. Other variables such as passive congestion (i.e., heart failure), postprandial hyperemia (with fasting required for 2 to 3 hours before testing), severe inflammation,<sup>47</sup> and steatosis can increase liver stiffness.<sup>43</sup> The technical failure rate of vibration-controlled transient elastography and the accuracy of liver-stiffness measurements are affected by obesity, because obesity increases the distance between the receiver and the liver.<sup>32</sup> This is particularly relevant for patients with nonalcoholic fatty liver disease.<sup>32</sup> Newer probes may have improved the performance of vibration-controlled transient elastography in obese patients<sup>48</sup>; however, patients in whom vibration-controlled transient elastography has failed because of severe obesity may benefit from magnetic resonance elastography. The two techniques are equally able to distinguish between advanced and nonadvanced fibrosis<sup>49</sup>; however, magnetic resonance elastography has a higher success rate among patients with severe obesity.<sup>50</sup>

Confounders of magnetic resonance elastography include inflammation, passive congestion, and a high hepatic iron burden.<sup>51</sup> Though relatively limited availability and cost prohibit widespread use, magnetic resonance elastography complements vibration-controlled transient elastography, playing a critical role in difficult cases. Biopsy is still available when both tests fail.<sup>52</sup>

Vibration-controlled transient elastography and magnetic resonance elastography provide additional information in patients with nonalcoholic fatty liver disease. The same machine can be used to determine whether steatosis is present. Vibration-controlled transient elastography with controlled attenuation parameter<sup>53</sup> and calculation of the proton-density fat fraction or spectroscopy

copy during MRI<sup>49</sup> are superior to ultrasonography for the detection of hepatosteatosis.

#### STRATEGIES FOR NONINVASIVE RISK STRATIFICATION

Risk assessment has shifted from fibrosis staging to the dichotomization of fibrosis as advanced or not advanced.<sup>16,17,32</sup> The goal is thus to categorize patients as having a low, an indeterminate, or a high likelihood of advanced fibrosis. Strategies that reserve biopsy for indeterminate results reduce the number of biopsies needed to accurately risk-stratify patients by more than 70%, as compared with biopsy-first approaches.<sup>14,54</sup> To incorporate noninvasive indexes into practice, the simplest strategy is to begin with a test that has a high negative likelihood ratio in order to rule out high-risk cases. Table 1 reviews the test characteristics of common, nonproprietary fibrosis risk scores and elastographic techniques. Serologic tests are readily available, but clinicians need to know that 28% of patients with nonalcoholic fatty liver disease, for example, are classified as having an indeterminate risk on the basis of both the Fibrosis-4 (FIB-4) score<sup>30</sup> and the NAFLD Fibrosis Score.<sup>31</sup> In addition, the positive likelihood ratio of noninvasive tests for fibrosis can be low. A useful strategy is to order two tests and seek concordant results. To this end, clinicians should order both a serologic test and an imaging or elastographic test during a single clinic visit,<sup>15,40,43,54</sup> so that patients can be assigned to one of three risk strata: concordant low risk, concordant high risk, or discordant or indeterminate results.<sup>43,44</sup> Approximately 21% of patients will have discordant or indeterminate results.<sup>27</sup> For these patients, the choice is to repeat the tests or perform a liver biopsy, depending on how the results might change management (Fig. 2). The results of each test can vary slightly on different days, and when tests are repeated at a follow-up visit, concordance is achieved — precluding the need for a biopsy — in as many as 70% of patients with discordant results.<sup>32</sup>

#### WHEN TO USE NONINVASIVE TESTS

Noninvasive assessments of liver fibrosis can serve many purposes in the management of liver diseases. First, noninvasive assessments can be used to determine whether patients with mild

abnormalities in liver chemical values should be referred to liver specialists. This is particularly relevant because of the epidemic of obesity and nonalcoholic fatty liver disease.<sup>31,55</sup> Serologic tests — namely, the NAFLD Fibrosis Score and FIB-4 — provide cost-effective, efficient risk stratification, especially when performed in the primary care clinic to identify patients who have advanced fibrosis or indeterminate scores, warranting referral to a specialist.<sup>14,15</sup>

Second, the likelihood of advanced fibrosis can be used to guide treatment decisions (e.g., in patients with chronic hepatitis B virus [HBV] infection and mildly elevated alanine aminotransferase levels).<sup>24,56</sup> Elevated values for liver stiffness in patients with HBV infection would indicate the need for antiviral therapy, and liver biopsy would not be necessary.<sup>24</sup> Similarly, some insurers require the results of noninvasive tests for prioritizing anti-HCV therapy given the high cost of the direct-acting antiviral drugs.

Third, noninvasive tests can predict which patients are at risk for adverse outcomes, including liver cancer, complications of portal hypertension, and death, with areas under the receiver-operating-characteristic curve of 0.80 or higher.<sup>40,41</sup> The higher the value, the more likely that a patient with any kind of liver disease will be at risk for disease-related complications and death.<sup>34,35,40</sup> For example, though a liver stiffness of 12.5 kPa may be associated with cirrhosis, values exceeding 20 kPa and those exceeding 50 kPa are incrementally more predictive of adverse outcomes.<sup>40,41</sup> Indeed, patients with platelet counts higher than 150,000 per cubic millimeter and liver stiffness below 20 kPa can forgo screening for esophageal varices because of the low risk of associated complications.<sup>57</sup> Although liver stiffness is likely to decrease with disease resolution (e.g., HCV eradication), studies are ongoing to determine whether such changes suggest reduced long-term risks.

#### NONINVASIVE DIAGNOSIS OF LIVER DISEASES

Roughly 8% of persons in the United States have elevated liver enzyme levels.<sup>58</sup> The medical history in conjunction with a focused serologic and radiologic evaluation is sufficient for diagnosis of liver disease in most instances.<sup>59</sup> The most



**Table 2. Undifferentiated Liver Disease.**

Disease	Noninvasive Test*	Prevalence†	
		Among Patients with Liver Enzyme Abnormalities (Study)‡	Among Patients Undergoing Biopsy after Negative Preliminary Evaluation
		percent	
NAFLD	Ultrasonography	41	75.7
Alcoholic liver disease	History	13.5	1.9
Hepatitis C	Hepatitis C antibody, confirmed with PCR	7.0	0
Drug-induced liver injury	History — diagnosis by exclusion	4.4 (Van Ness and Diehl <sup>65</sup> )	4.7
Hemochromatosis	Transferrin saturation >45%, confirmed with genotyping for hemochromatosis	2.8 (Van Ness and Diehl <sup>65</sup> )	0.5
Autoimmune hepatitis	Antinuclear antibody, anti-smooth-muscle antibody, IgG levels	1.8 (Adams et al. <sup>66</sup> )	1.8
Hepatitis B	Hepatitis B surface antigen with PCR	0.96	0
Primary biliary cholangitis	Antimitochondrial antibody	0.2	1.2
Primary sclerosing cholangitis	MRCP	0.2	1.1
Wilson's disease	Ceruloplasmin <20 mg/dl, confirmed with urine copper evaluation	0.16 (Tapper et al. <sup>67</sup> )	0
Alpha-1 antitrypsin deficiency	Alpha-1 antitrypsin level <80 mg/dl and confirmatory phenotype (e.g., PiZZ)	0.16 (Tapper et al. <sup>68</sup> )	0

\* MRCP denotes magnetic resonance cholangiopancreatography, PCR polymerase chain reaction, and PiZZ proteinase inhibitor phenotype.  
† Data on prevalence are from population studies in the United Kingdom<sup>55</sup> and the United States<sup>58</sup> unless otherwise indicated. The proportion of diseases after biopsy in patients who had undergone serologic and radiologic evaluation was pooled from the three applicable studies.<sup>62-64</sup> The prevalences of other conditions in biopsy studies were 5.6% for normal liver, 1.1% for granulomatous diseases, 0.4% for secondary biliary cirrhosis, and 0.2% each for amyloidosis, glycogen storage disease, and porphyria cutanea tarda.  
‡ NAFLD is defined in epidemiologic studies by the presence of steatosis on ultrasonography, which can be insensitive.

common underlying liver diseases are nonalcoholic fatty liver disease,<sup>55,60</sup> alcoholic liver disease,<sup>55,58,60,61</sup> and viral hepatitis.<sup>58</sup> In Table 2, we pooled data on the proportion of specific liver diseases accounting for elevated liver enzyme levels from prospective studies of unselected patients in the third National Health and Nutrition Examination Survey (NHANES III) and a primary care population in the United Kingdom (supplemented with data from other sources for estimates of rare diseases not tested in NHANES).<sup>55,58</sup> The most important determinant of the yield of noninvasive testing is the sensitivity of the medical history for alcoholic liver disease and of imaging for hepatosteatosis, because there are no serologic tests for the diagnosis of these conditions. After excluding patients with these conditions from further evaluation, the pretest probability of testable diseases will rise. When we pooled the three prospective studies that evaluated the usefulness of liver biopsy in

patients with unknown diagnoses after preliminary evaluation, the ultimate diagnosis was nonalcoholic fatty liver disease or alcoholic liver disease in 77% of cases (Table 2).<sup>62-64</sup> For patients suspected to have nonalcoholic fatty liver disease because of underlying metabolic syndrome or obesity and nondiagnostic ultrasound results, vibration-controlled transient elastography with controlled attenuation parameter or MRI techniques may confirm the presence of hepatosteatosis.<sup>49,53</sup> Liver biopsy, however, continues to play a role in the management of nonalcoholic fatty liver disease. Despite poor interobserver concordance,<sup>3</sup> only a biopsy can differentiate simple steatosis from nonalcoholic steatohepatitis. Circulating markers of inflammatory activity such as cytokeratin 18 and plasminogen activator inhibitor 1 appear to be promising,<sup>69,70</sup> but neither is validated for clinical practice. Currently, no drugs have been approved by the Food and Drug Ad-

ministration (FDA) for nonalcoholic fatty liver disease. Given the lack of an established surrogate for clinical outcomes in patients with nonalcoholic fatty liver disease, the FDA requires evidence of histologic improvement and therefore the need for paired biopsies in clinical trials. Drug development for nonalcoholic fatty liver disease is hindered by cost and by the tendency for patients to decline multiple biopsies.<sup>13</sup> Hepatologists have advocated the use of surrogate measures (e.g., vibration-controlled transient elastography or magnetic resonance elastography), but histologic assessment is still required for clinical-trial end points.<sup>71</sup>

Biopsy remains important for the diagnosis of some liver diseases — notably, autoimmune hepatitis, small-duct primary sclerosing cholangitis, and antimitochondrial antibody-negative primary biliary cholangitis — and for treatment decisions in some cases of chronic HBV infection. Finally, in rare cases, biopsy is necessary to diagnose infiltrative diseases such as amyloidosis, lymphoma, and granulomatous hepatitis.

#### MANAGEMENT OF SOLID LIVER LESIONS

Multiphasic, contrast-enhanced, cross-sectional imaging (CT and MRI) can be used to discern the cause of focal liver lesions on the basis of their vascular and biliary physiological features in relation to the timing of images obtained after the administration of contrast material. Biopsy is now rarely needed to distinguish benign from malignant lesions.


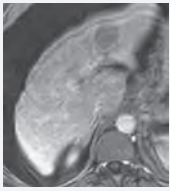
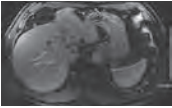
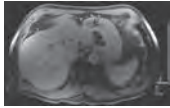

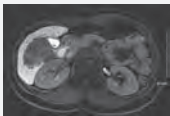
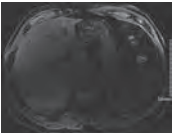
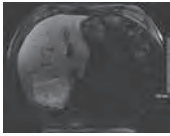
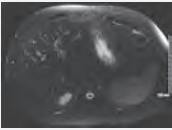
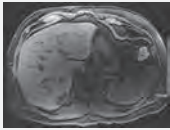
Hepatocellular carcinoma is the most common primary liver cancer.<sup>72</sup> Biopsy of hepatocellular carcinoma is associated with risks, including tumor seeding (in 3% of cases), potentially fatal bleeding (1 to 2%), and, owing to sampling error, a low negative predictive value (14%).<sup>73,74</sup> To avoid these complications, candidacy for transplantation, which is a major method of treatment for hepatocellular carcinoma, is mostly based on a radiologic diagnosis. However, a 2003–2005 study involving 789 patients who underwent liver transplantation for hepatocellular carcinoma showed that 20% of the patients had benign nodules.<sup>75</sup> Diagnostic criteria for hepatocellular carcinoma have since been refined on the basis of the timing of images obtained

after intravenous injection of contrast material (Fig. 3). The time required for intravenous contrast material to circulate into the arteries and, ultimately, the portal venous system is well known. Images can thus be obtained during the expected arterial and portal–venous phases of contrast circulation. In contrast to normal liver, which receives most (approximately 80%) of its blood from the portal vein, hepatocellular carcinoma receives blood primarily from the hepatic artery. Accordingly, it receives a contrast load (indicated by hyperintensity) during the arterial phase, with washout, or relative hypointensity, during the portal–venous phase (when the normal liver appears brighter). Use of these findings as diagnostic criteria for hepatocellular carcinoma has a sensitivity of 74 to 80% and a specificity of 89 to 97%.<sup>72</sup> Although imaging is less accurate for the diagnosis of cholangiocarcinoma, biopsy is considered unnecessary for patients with characteristic imaging features (Table 3).<sup>77</sup> If uncertainty remains after imaging, small lesions can be monitored by means of serial imaging in centers where decisions are made at a multidisciplinary tumor conference.<sup>78</sup>

Given the limitations of biopsy, as well as innovations in imaging and systems of care, primary liver cancers are most often diagnosed on the basis of imaging studies alone in clinical practice. Histologic confirmation of the diagnosis is thought to be most useful when imaging is inconclusive. There are two drawbacks of this practice. First, the systematic avoidance of biopsy for the diagnosis of hepatocellular carcinoma may have slowed progress in understanding the biologic features of these tumors and in developing targeted therapies for patients with advanced hepatocellular carcinoma. Second, as noted above, some patients may have benign tumors.<sup>75</sup> Although the use of biopsy has been reduced in the management of liver tumors, future research may point toward a larger role for biopsy.

#### ROLE OF LIVER BIOPSY IN CURRENT PRACTICE

Multiple forces have radically changed the role of liver biopsy in the management of liver diseases. First, noninvasive alternatives have been shown to be reliable in detecting advanced fibrosis or cirrhosis and in diagnosing many liver dis-

Lesion	Classic Biology	Diagnostic Test	Features	Image	
				Panel A	Panel B
Hepatocellular carcinoma	Receives blood supply primarily from the hepatic artery (in contrast to normal liver, which receives most blood from the portal vein)	Multiphasic, contrast-enhanced, cross-sectional imaging (CT or MRI)	Increased contrast enhancement in arterial phase (Panel A), contrast washout during portal venous phase (Panel B), peripheral rim enhancement		
Cholangiocarcinoma	Receives blood from both hepatic artery and portal vein; has an associated extensive desmoplastic reaction	Multiphasic, contrast-enhanced, cross-sectional imaging (CT or MRI)	Progressive contrast enhancement in both arterial and venous phases; early (Panel A) and late (Panel B) venous phases		
Hepatocellular adenoma (HCA)	Receives blood supply primarily from the hepatic artery; lacks bile ducts	Multiphasic MRI with contrast agent that is secreted into bile	Early arterial hyperenhancement, isointense portal venous phase (Panel A), minimal uptake of biliary-specific contrast agents in delayed phases (Panel B)		
Focal nodular hyperplasia (FNH)	Has a central scar (unlike HCA) comprising fat and fibrous tissue	Multiphasic MRI with contrast agent that is readily taken up by hepatocytes; highlights difference between HCA and FNH	Diffuse enhancement in arterial phase, isointense signal in T1-weighted phase (Panel A), central scar in T2-weighted phase, with enhancement in late phase (Panel B)		
Hemangioma	Septate clusters of vascular endothelium are lined with hepatic arterial blood supply	Multiphasic MRI; intensity of contrast agent is the same as in the artery	Typically hypointense on T1-weighted images and hyperintense on T2-weighted images (Panel A), with peripheral nodular contrast enhancement and centripetal fill-in (Panel B)		

**Figure 3. Radiologic Characteristics of Common Liver Lesions.**

Grazioli et al.<sup>76</sup> have reported on the differential diagnosis of hepatocellular adenoma and focal nodular hyperplasia.

eases. Long-term clinical outcomes can be predicted by means of noninvasive tests that can accurately differentiate mild from advanced fibrosis.<sup>5,16-18</sup> Furthermore, noninvasive tests are safer and cheaper than biopsy, and they can be repeated over time to monitor disease progression.

Second, many indications for liver biopsy are disappearing. This is most evident in the management of hepatitis C. Until recently, the available therapies were interferon-based, required injections, and had numerous adverse effects and limited efficacy. Biopsy was a means of protecting patients with mild fibrosis from the harms of therapy. Current therapies with direct-acting antiviral drugs are administered orally, have few adverse effects, and can result in a virologic cure in 95% or more of patients, including

those with cirrhosis.<sup>79</sup> Consequently, guidelines recommend treatment for all patients with hepatitis C.<sup>80</sup>

CONCLUSIONS

Noninvasive tests have not replaced liver biopsy but have sharply reduced the need for it. This shift has greatly improved our ability to care for patients with liver diseases. However, the limitations of these noninvasive tests must be recognized. Liver biopsy will continue to have a role in diagnosing some liver diseases, resolving indeterminate stages of fibrosis, and addressing specific research questions.

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# Insights from clinical research completed during the west Africa Ebola virus disease epidemic

Amanda Rojek, Peter Horby, Jake Dunning



The west Africa Ebola virus disease (EVD) epidemic was extraordinary in scale. Now that the epidemic has ended, it is a relevant time to examine published studies with direct relevance to clinical care and, more broadly, to examine the implications of the clinical research response mounted. Clinically relevant research includes literature detailing risk factors for and clinical manifestations of EVD, laboratory and other investigation findings in patients, experimental vaccine and therapeutic clinical trials, and analyses of survivor syndrome. In this Review, we discuss new insights from patient-oriented research completed during the west Africa epidemic, identify ongoing knowledge gaps, and suggest priorities for future research.

## Introduction

The world's largest ever epidemic of Ebola virus disease (EVD) probably commenced in December, 2013, following the infection of the presumed index case, a 2-year-old child living in rural Guinea.<sup>1</sup> The subsequent outbreak soon crossed into Sierra Leone and Liberia and case numbers escalated rapidly. When WHO acknowledged in August, 2014, that the outbreak was a public health emergency of international concern, there were already 1711 reported cases and there had been 932 deaths.<sup>2</sup> By the end of the epidemic, 28 646 cases and 11 323 deaths had been reported,<sup>3</sup> but the true numbers are likely to be much higher. The epidemic had far-reaching effects in west Africa, including enormous economic costs and significant strains on already stretched health-care systems.<sup>4,5</sup> A staggering 881 health-care workers were infected and 513 died.<sup>6</sup>

The focus of global response efforts was, quite rightly, to provide humanitarian assistance and medical care, and to interrupt chains of transmission.<sup>7</sup> But there were also calls from WHO, funding bodies, and governments to urgently increase the scale of scientific research to respond to the rapidly growing EVD epidemic.<sup>8</sup> Before 2014, outbreaks were short-lived, occurred in remote locations, and involved relatively small case numbers. Such factors, coupled with little research interest and funding, meant that the general understanding of EVD was limited. The west Africa epidemic provided an important opportunity to improve patient outcomes through clinical studies that would enhance knowledge and allow investigation of potential interventions. There were major hurdles to overcome, however, including logistical challenges,<sup>9,10</sup> and ethical and societal considerations<sup>11,12</sup> that could affect the ability to reach conclusions within the lifetime of the epidemic.

This Review summarises published findings from clinical research completed during the epidemic, and then discusses the implications for countries at risk of EVD outbreaks, ongoing clinical research gaps, and priorities moving forward. There was a broad range of research done during this period, so we have placed emphasis on patient-centred developments and progress made investigating Ebola virus vaccines (appendix).

## Clinical features of EVD

In the west Africa epidemic, the greatest burden of EVD was in young adults (median age 32 years, IQR 21–42).<sup>13</sup> It is unclear whether this burden represents an increased risk in young adults (perhaps because of increased exposure) or a case ascertainment bias (if children or the elderly were less likely to be in the official count). There was no marked gender difference in disease prevalence (48·8% of probable and confirmed infections were in men).<sup>14</sup>

We now know that young age is a predictor of death (odds ratio [OR] per year of life 0·91, 95% CI 0·85–0·97) and that children tend to deteriorate rapidly, with a median of 3 days from admission to an Ebola treatment centre (ETC) to death in a cohort of 300 children.<sup>15,16</sup> Likewise, some data show that mortality is higher in patients older than 45 years and in men.<sup>13,14,17–20</sup> The previously published case fatality rates (CFRs) for maternal (90%) and neonatal EVD (100%) might be an overestimation,<sup>21</sup> since there have been subsequent case reports of maternal<sup>22,23</sup> and, very rarely, neonatal survival.<sup>24</sup> Without systematic data collection, however, the prognosis for pregnant women is uncertain.

Although first described as Ebola haemorrhagic fever, because of the frequency of bleeding observed during the initial outbreaks of 1976,<sup>25,26</sup> a spectrum of illness was evident in the west Africa epidemic and haemorrhage, when present, was a late finding associated with fatal disease.<sup>27,28</sup> The hallmark of advanced disease in this epidemic was severe gastrointestinal illness.<sup>13,18,29–33</sup>

The most frequent symptoms at presentation (table 1) were fever, fatigue, anorexia, vomiting, diarrhoea, headache, and abdominal pain.<sup>13,18,31–33</sup> Anecdotal reports of large volume, cholera-like diarrhoea emerged from ETCs in west Africa, and volumes of up to 10 L of diarrhoea per day were observed in medically evacuated patients.<sup>29,30</sup> Notably, fever was absent in at least 10% of patients,<sup>13,18,31–33</sup> which has important implications for clinical triage and case definitions that include fever as a prerequisite symptom. Less common clinical manifestations, including confusion, conjunctivitis, and hiccups,<sup>20,33</sup> had good discriminatory importance in identifying EVD cases in all patients presenting to ETCs

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See Online for appendix

## Review

	Signs and symptoms <sup>13</sup> reported in more than 10% of patients with acute Ebola virus disease	Investigational findings that have been reported during acute Ebola virus disease	Signs and symptoms during survivor syndrome from Ebola virus disease
General	Fever, fatigue, hiccups	Raised pro-inflammatory markers, including CRP; elevated lactate <sup>34</sup>	Fatigue, <sup>35-37</sup> depression, <sup>36-39</sup> anxiety, <sup>36,37,39</sup> insomnia <sup>35,36,38</sup>
Neurological and visual	Headache, confusion	Detectable Ebola virus RNA in the cerebrospinal fluid; <sup>40,41</sup> diffuse swelling, microvascular occlusions as observed by MRI <sup>42</sup>	Difficulty concentrating, mood changes, and memory loss; <sup>38,39</sup> headaches; <sup>35,36,38,43</sup> dizziness; <sup>38</sup> difficulties hearing; <sup>35,37-39,44</sup> visual disturbances; <sup>35-37,39,43,44</sup> peripheral paraesthesia or dysaesthesia <sup>37</sup>
Cardiovascular	Chest pain	Bradycardia, <sup>45</sup> arrhythmias as shown by electrocardiogram; <sup>46</sup> myocarditis shown during MRI <sup>47</sup>	Chest pain, <sup>36,38,43</sup> palpitations <sup>35,37,38</sup>
Pulmonary	Cough, dyspnoea, sore throat	Pulmonary oedema and pulmonary effusion as observed on x-ray and USS <sup>46</sup>	Dyspnoea <sup>37</sup>
Gastrointestinal	Anorexia, vomiting, diarrhoea, abdominal pain, odynophagia	Paralytic ileus and bowel wall oedema shown by USS <sup>39,48</sup>	Anorexia, <sup>35,38</sup> abdominal pain, <sup>35,36,38,43</sup> constipation <sup>38</sup>
Hepatobiliary	Jaundice	Transaminitis with high AST:ALT ratio <sup>34,49</sup>	..
Renal, urological, and electrolytes	..	Acute kidney injury, <sup>34,50,51</sup> raised creatine kinase, <sup>34</sup> hypokalaemia <sup>34,49,51</sup> or hyperkalaemia, <sup>34</sup> hyponatraemia, <sup>34</sup> hypocalcaemia, <sup>49</sup> hypoglycaemia <sup>45</sup>	Decreased libido; sexual dysfunction and testicular pain <sup>36,38</sup>
Haematological	Clinically significant haemorrhage uncommon, likely to be more frequent in pregnant women.	Leucopenia, thrombocytopenia, raised INR, haematoconcentration <sup>34</sup>	Anaemia <sup>35</sup>
Skin and musculoskeletal	Myalgia, arthralgia, conjunctivitis	..	Arthralgia; <sup>35,36,39,43,44</sup> myalgia; <sup>36</sup> alopecia, skin peeling, and pruritus <sup>35,36,38,39,43</sup>

USS=ultrasound scan. ALT=alanine transaminase. AST=aspartate transaminase. CRP=C-reactive protein. INR=international normalised ratio.

**Table 1: Clinical manifestations of investigational findings in Ebola virus disease, reported by studies done during the west Africa epidemic**

and therefore remain helpful for presumptive clinical diagnosis in the context of a known outbreak.

A cross-sectional seroepidemiological study done in Sierra Leone found that 14 (7.5%) of 187 individuals who had not been diagnosed with EVD had detectable anti-Ebola glycoprotein antibodies.<sup>52</sup> 12 of the 14 denied any symptoms compatible with EVD. These results, when considered alongside related data from previous outbreaks,<sup>53,54</sup> suggest that a proportion of Ebola virus infections are subclinical, although the contribution of such cases to transmission or herd immunity is unknown and the specificities of serological assays need to be considered.

WHO's estimated CFR for the epidemic was 70% (95% CI 69–72).<sup>32,55</sup> Overall, mortality was lower in patients admitted to hospital (CFR 61%, 95% CI 59–62) compared with patients not admitted to hospital (88%, 86–90).<sup>32</sup> Small hospital series have reported substantially improved survival (eg, CFR 32% in a hospital in Sierra Leone<sup>56</sup>), but these data should be interpreted with caution, since there are many potential explanations for the variability in CFR. For example, although medical intervention might have conferred a survival benefit, the influence of case selection bias (arising from self-presenting patients who are not representative of patients with EVD in the community) or a survival bias (when the most unwell patients succumbed to disease before admission) has not been

fully assessed. The 19% CFR seen in patients treated in Europe and the USA was much lower than that reported in west Africa;<sup>57</sup> although not confirmed, possible explanations include fewer untreated comorbidities and lower levels of viraemia at admission, and access to advanced physiological support and experimental therapies that were not available routinely in the three most affected countries in west Africa.

### Complications of acute illness

EVD can be a severe and complex multisystem disease, with inflammation, vascular leakage, hypovolaemic shock, electrolyte disturbance, and direct organ damage all contributing to illness. Most existing knowledge about the pathogenesis of EVD has come from in-vitro studies and animal models (reviewed elsewhere<sup>58-60</sup>), and limited histopathological data from previous human cases of EVD.<sup>60</sup> Improved characterisation of the broad spectrum of organ involvement (table 1) is an important contribution to knowledge about EVD from this outbreak.

### Gastrointestinal complications

The mechanism of severe diarrhoea in EVD is unclear. Although clinical descriptions of large volume, so-called rice water diarrhoea draws analogy with cholera and implies a secretory process, previous autopsy findings indicate that intestinal wall inflammation also occurs.<sup>60</sup>

There have been small gains in explaining why patients experience abdominal pain (including peritonism in a subset of cases);<sup>29,46,48</sup> with case reports from resource-rich countries identifying paralytic ileus by ultrasonography.<sup>29,48</sup> In one case, marked bowel wall oedema was observed; the treating clinicians speculated that both viral-mediated damage and iatrogenic hypoproteinaemia might have contributed to this finding.<sup>29</sup> They also suggested that an inflamed gastrointestinal tract was likely the source of the bacteraemia observed in this patient, but there are few similar data to suggest whether this was a common phenomenon in west Africa.

### Renal complications

Renal dysfunction is more common than previously thought. In one series of 150 patients, acute kidney injury (defined according to the Risk, Injury, and Failure; Loss; and End-stage kidney disease [RIFLE] criteria) occurred in 50% of patients and was an independent predictor of mortality (OR 5.84, 95% CI 1.15–29.58);<sup>34</sup> a similar pattern has been seen in other cohorts.<sup>19,50,51</sup> Importantly, these studies suggest that renal dysfunction occurs earlier in the disease trajectory than previously recognised and, at times, before the onset of severe vomiting and diarrhoea. For these patients, this early onset of disease manifestation indicates a mechanism partly independent of prerenal hypovolaemia because of gastrointestinal losses.<sup>34,61</sup> There are probably various contributors, including renal hypoperfusion from septic shock or, in patients with disseminated intravascular coagulopathy, thrombus formation in the renal microvascular system, or rhabdomyolysis.<sup>34</sup> In particular, the risk of acute kidney injury from rhabdomyolysis has yet to be fully elucidated. Although approximately half of patients with EVD experience myalgia<sup>32</sup> and suggestive laboratory findings of raised creatine kinase<sup>34,57,62</sup> and hyperkalaemia have been reported, identification of true rhabdomyolysis has been limited by insufficient urine myoglobin measurement. Furthermore, there have been few mechanistic studies of Ebola-virus-induced muscle damage.

Hyperkalaemia has been reported in 13% of patients with EVD in one series based in west Africa.<sup>34</sup> This finding is plausible given the prevalence of acute kidney injury and the hypothesis of rhabdomyolysis, but hyperkalaemia has been reported infrequently in other series, both in west Africa<sup>51</sup> and in medically evacuated patients (albeit confounded by frequent use of renal replacement therapy in this setting). Therefore, there is no certainty and caution is required when interpreting potassium findings obtained under field conditions, since erroneous readings of hyperkalaemia due to specimen haemolysis is possible. Hypokalaemia is common,<sup>34,49,51</sup> and although this is not an unexpected finding, given the severity of gastrointestinal losses in EVD, the variability in reported blood potassium disturbances highlights the necessity of biochemical testing to inform clinical decision making. Although data

are limited, other commonly observed metabolic abnormalities include hyponatraemia, hypocalcaemia, and hypomagnesaemia.<sup>34,49,57</sup> Additionally, severe and frequent hypoglycaemia has been described in children with EVD.<sup>16</sup>

### Hepatic complications

There is little new knowledge regarding liver injury in EVD. Normal bilirubin concentrations were considered normal in patients with EVD in west Africa, but transaminitis was common, typically with a high aspartate transaminase to alanine transaminase ratio.<sup>19,34,49,57</sup> It is not clear whether the increased ratio represents liver damage, muscle damage, or both.<sup>34,57,62</sup> A high AST concentration during the first week of illness was shown to be associated with fatal outcome.<sup>63</sup> In the same study, AST correlated with the Ebola virus cycle threshold value during PCR analysis, suggesting it could be used as a surrogate marker of viral load.<sup>63</sup>

### Respiratory complications

Dyspnoea and tachypnoea were observed frequently in west African patients with EVD. Difficulty in breathing was reported in between 41%<sup>20</sup> and 50% of patients.<sup>64</sup> Tachypnoea was observed in all 35 patients in one cohort.<sup>19</sup> Other groups have reported much lower rates of dyspnoea,<sup>10,33,65</sup> but there is likely to be variability in reporting since the intensity of monitoring is varied and dyspnoea is a subjective symptom. Acute lung injury has been observed in patients with EVD who were medically evacuated and had access to more intensive monitoring. In this setting, hypoxaemia was observed in 14 (52%) of 27 patients and non-invasive or invasive mechanical ventilation was required in nine patients (33%).<sup>57</sup> Tachypnoea could occur secondary to acidosis, which is common in EVD,<sup>19,34,51</sup> but pulmonary oedema associated with vascular leakage or fluid overload might also contribute to this condition.<sup>30,48</sup> Direct viral pneumonitis was suggested as the cause of acute respiratory failure in one case, as shown by interstitial pulmonary infiltrates and the detection of Ebola virus in bronchial aspirate fluid.<sup>66</sup>

### Cardiovascular complications

Further reports of inappropriate bradycardia in patients with EVD surfaced during this epidemic.<sup>45</sup> Because some patients in this report were also encephalopathic, the authors suggested a possible central neurological cause, as opposed to the previous hypothesis of toxin-mediated damage.<sup>45</sup> Arrhythmias have been reported in medically evacuated patients<sup>46</sup> and have been the presumed proximal cause of sudden death in some patients with EVD during acute illness or during early recovery<sup>67</sup> in west Africa. Electrolyte disturbances could be possible precipitants, but there is also evidence that viral myocarditis can occur during acute illness and recovery.<sup>35,47</sup> Additionally, a hypercoagulable state has been shown during early



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recovery,<sup>68</sup> although this raises the possibility of venous thrombosis and pulmonary thromboembolism,<sup>35</sup> evidence of these complications is incomplete. Additionally, higher haemoglobin concentration and haematocrit were associated with mortality in a west Africa cohort;<sup>34</sup> this finding might have resulted from haemoconcentration, but whether the increase in blood viscosity has clinically important consequences is unknown.

### Neurological complications

Neurological complications were common in patients in west Africa and included headache (61%), confusion (13%), and coma or unconsciousness (6%).<sup>32</sup> A third of patients treated in Europe and the USA were encephalopathic at some point during their illness.<sup>57</sup> Encephalitis during acute illness and early recovery has been described, with detection of Ebola virus RNA in cerebrospinal fluid.<sup>40,41</sup> This association alone is insufficient to assume an infective mechanism, but is supported by isolation of virus from cerebrospinal fluid in a survivor with meningoencephalitis.<sup>69</sup> Detailed radiological investigation is challenging even in resource-rich settings, but MRI brain imaging done at day 33 of illness has shown microvascular disease and ischaemia in a patient with meningoencephalitis.<sup>42</sup>

### Inflammatory response

The association between high viral load in blood and increased mortality is now well established,<sup>18–20,34,64,70–72</sup> and has been shown to follow a sigmoid (logistic) function.<sup>73</sup> Severe EVD is associated with an intense inflammatory response, characterised by high concentrations of pro-inflammatory mediators.<sup>60,74,75</sup> The kinetics of soluble immune mediators and biomarkers in serial blood samples obtained from seven patients with EVD treated in the USA showed an association between more severe disease and biomarkers suggestive of endothelial or coagulatory dysfunction. These patients also showed a comparative absence of biomarkers indicative of an immune response (compared with those found in patients with less severe EVD).<sup>76</sup> Two case series reported high concentrations of C-reactive protein and lactate, especially in fatal cases.<sup>34,57</sup>

### Co-infections and sepsis

There are new and unexpected findings describing how concurrent infections affect EVD prognosis. Analysis of blood samples from 1182 patients infected with Ebola virus found that patients with *Plasmodium* spp parasitaemia were 20% more likely to survive, even after accounting for the mortality risk factors of marked Ebola virus viraemia and increasing patient age.<sup>77</sup> In the same study, the survival advantage was independent of treatment with antimalarial drugs, and administration of different antimalarial drugs failed to improve survival in mice infected with EVD. The authors hypothesised that concurrent *Plasmodium* sp infection might moderate the

host immune response, perhaps by reducing the exuberant cytokine response observed in EVD.<sup>77</sup> By contrast, a separate study did multivariate analysis on data from 1047 cases and found that malaria parasite co-infection was an independent determinant of fatal outcome, but only for children who were aged 5–14 years; all patients in this study received antimalarial therapy.<sup>78</sup> The reasons for these discrepant findings are unclear.

A study of 49 patients with EVD found that co-infection with GB virus C was associated with improved survival.<sup>79</sup> Similar to the hypothesis for the effect seen with concurrent *Plasmodium* sp infection, GB virus C might also have beneficial immunomodulatory functions in EVD infection.<sup>77</sup> Studies showing the effect of HIV co-infection on survival in EVD have either not been done or have yet to report their findings.

Physiological and biochemical findings that would fulfil the commonly accepted criteria for septic shock have been described for patients with EVD treated in Europe and the USA. It seems likely that sepsis and septic shock also occurred in many patients with EVD treated in west Africa, but there are insufficient data to confirm this. Sepsis could be caused by Ebola virus infection alone, or by bacterial co-infections (these have not been investigated systematically).<sup>29</sup>

### Supportive care

Supportive care remains the principal management strategy for patients with EVD. Several authorities advocate focusing efforts on correcting gastrointestinal fluid losses and electrolyte imbalances, and preventing hypovolaemic shock.<sup>80</sup> Recommended components of care often included oral or intravenous fluids, analgesia, antiemetics and antidiarrhoeal medications alongside empirical antimicrobials and antimalarials.<sup>81,82</sup>

The lower case fatality rate in patients treated in the USA and Europe (19%) suggests that intensive supportive care strategies can contribute substantially to improved survival.<sup>57</sup> Trials of supportive care were not completed during the west Africa EVD epidemic, however, and the evidence base for defining optimal supportive care for EVD remains insufficient.<sup>83</sup> Intensive intravenous fluid resuscitation was shown previously to be harmful in severe paediatric infections in resource-limited settings, albeit in a different context to EVD; therefore, a universal fluid resuscitation protocol for ETCs could potentially cause harm in some patients.<sup>84</sup> The complexities of detecting and correcting abnormalities in fluid distribution and organ perfusion have been shown by studies of patients treated in the USA and Europe.<sup>57,85</sup> Some have questioned whether EVD-associated sepsis differs significantly from bacterial or fungal sepsis and, accordingly, whether applying general principles of sepsis management (or administering experimental sepsis treatments) to patients with EVD could improve survival.<sup>80,86</sup>

Several interventions have been used routinely in some ETCs but not in others, with little evidence of

their benefit or risks. For example, the role of empirical vitamin K remains unclear,<sup>87</sup> given the limited understanding of the frequency and mechanisms of coagulopathy in EVD. Non-steroidal anti-inflammatory drugs were prescribed in some centres,<sup>56</sup> despite their potential to worsen gastrointestinal and renal complications. Loperamide is known not to confer benefit in patients with cholera, but it is uncertain whether a similar, secretory process causes the large volume diarrhoea described in EVD. Additionally, paralytic ileus is a known complication of EVD and a contraindication to loperamide use, but might go unrecognised in a typical ETC setting. The apparent variability of electrolyte disturbances also raises concerns about routine empirical electrolyte supplementation in the absence of blood electrolyte monitoring.

Any future trials of supportive care strategies in EVD will be challenging if new outbreaks are more typical (ie, smaller and of shorter duration), but high-quality supportive care is clearly a major factor influencing survival and it is important that recommended supportive care strategies are evidence-based. An expert consensus statement on the optimal package of supportive care for EVD in various settings would be a helpful interim measure, even more so if this identified the most important evidence gaps to guide the design of prospective clinical studies should a situation arise where such trials were possible.

## Survivors

The enormity of the west Africa outbreak has led to an unprecedented number of EVD survivors. The most frequently reported post-EVD complications in this epidemic (table 1) are consistent with previous outbreaks.<sup>88,89</sup> These include arthralgia, visual disturbances (including uveitis and loss of visual acuity), hearing impairments, myalgia, fatigue, abdominal pain, and sleep disturbances.<sup>35,36,38,43,44</sup> Neurological deficits were reported infrequently before this outbreak, but now appear to be an important contributor to morbidity.<sup>39</sup> Psychological distress in response to a life-threatening illness could also contribute to neurocognitive manifestations.<sup>90</sup> Survivors report very poor social acceptance by their communities and are often stigmatised.<sup>36,38</sup> Although this is known to affect survivor confidence and social engagement,<sup>38</sup> long-term psychological needs are unknown.

The pathogenic mechanisms that underlie EVD sequelae remain poorly understood. There is a long-held assumption that autoimmune or post-infectious inflammatory processes play prominent roles, but an association between viral replication in immune privileged sites and late complications in some survivors is newly established.<sup>69,91</sup>

Ebola virus was isolated from the aqueous humour of a survivor with panuveitis, 14 weeks after diagnosis.<sup>91</sup> The total duration of viral sequestration was unknown, but

was less than 18 months.<sup>92</sup> Additionally, infectious virus was detected in the cerebrospinal fluid of a survivor with meningoencephalitis, 9 months following acute illness.<sup>69</sup> At this time, there was also a transient viraemia, thought to represent a so-called spillover of Ebola virus from its site of replication in the CNS.<sup>24,69</sup> Both of these patients were medically evacuated to settings with advanced care and received experimental therapies. Therefore, it is unclear if the nature, timing, and severity of these complications are representative of sequelae seen in west Africa. Follow-up of 151 survivors in Sierra Leone showed that late recrudescence, defined as illness or death that could not be attributed to a non-EVD related cause after a period of full recovery from confirmed EVD, was rare (maximum estimate of 0.7%).<sup>93</sup>

Persistence of Ebola virus in body fluids had been shown before this outbreak<sup>94</sup> but the long duration of persistence has been an unexpected finding.<sup>95</sup> For example, viral RNA is detectable in semen up to 18 months following discharge from an ETC.<sup>96</sup> There are few data available to estimate the proportion of male survivors affected. In one small convenience sample of survivors who were at varying durations into recovery, the overall prevalence of viral RNA positive semen was 49%.<sup>97</sup> Determinants of viral persistence in semen require further study.

There is also new evidence that women who recover from EVD during pregnancy can harbour persistent virus in the amniotic fluid and placenta and deliver an infected, stillborn fetus.<sup>23,98,99</sup> Additionally, there are reports of viral persistence in other body fluids that would not be considered to be immune privileged, albeit for a briefer timeframe. Case reports suggest shorter-lived persistence of viable virus (and viral RNA) in urine and viral RNA in sweat<sup>85,100</sup> and contribute to existing knowledge of persistence in vaginal, rectal, and conjunctival swab specimens and in breast milk.<sup>94,101,102</sup> Some caution is required when interpreting these small case studies; for example, the method used to collect a positive urine sample from a male patient was not described, raising the possibility of cross-contamination by virus present in semen.<sup>85</sup> Nonetheless, the viral kinetics of persistence in these fluids require closer examination, particularly when there are implications for guidance on preventing sexual transmission or potential transmission by breastfeeding.

The phenomenon of viral persistence means that, in limited circumstances, survivors can act as a reservoir for ongoing disease transmission. Convincing evidence now exists to show that men can transmit Ebola virus to women during sexual intercourse.<sup>103,104</sup> The prolonged duration of viral persistence in semen raises the possibility of sexual transmission occurring long after the resolution of acute illness. There is evidence that a flare of EVD in Guinea, which occurred months after the end of the Guinean outbreak, was caused by male-to-female sexual transmission (at approximately 470 days

after initial illness in the male partner).<sup>103</sup> There are no population-level data that predict the risk for sexual partners of EVD survivors, but the low incidence of new flares of disease provides some indication that transmission leading to disease is uncommon. There is no published, definitive evidence of female-to-male sexual transmission having occurred, or of mother-to-child transmission by breastfeeding.

There are several ongoing research priorities for survivors. Long-term studies are a priority because the longest survivor follow-up reported to date has been just over 2 years,<sup>88</sup> with ongoing symptoms reported at that time. Of note, there are no descriptions of the effect of EVD on childhood development and outcomes, and although the small amount of evidence so far suggests that EVD survivors might be at greater risk of pregnancy-related complications including stillbirth, these data require comparison with age-matched controls.<sup>24,105</sup> The risk of EVD recurrence and subsequent transmission by survivors is a key concern and so biological sampling in survivor cohorts is important to direct guidance on prevention strategies.<sup>106</sup> Although a biological sampling approach (based on sequential negative samples) seems reasonable, we first need to know the natural history of persistence (ie, whether detection of Ebola virus in semen can follow non-detection in earlier samples). Clinical trials of experimental drugs to clear persistent virus have commenced (registration numbers NCT2818582 and NCT02739477). To date, many of the available viral persistence studies have relied on reverse transcriptase PCR to identify viral presence, but future studies should also focus on identifying live virus, which is more indicative of potential transmission risk.

## Therapeutics

### Experimental treatments

Before the west Africa epidemic, experimental therapeutics had not been studied in patients with EVD, although transfusion of blood from convalescent patients had been tried.<sup>107</sup> The sheer scale of the west Africa epidemic demanded that effective, specific treatments should be identified and made available to patients as soon as possible. Accordingly, an expert panel was convened by WHO in September, 2014, to prioritise promising candidates for clinical trials.<sup>12</sup>

Disappointingly, no clinical trial of potential therapeutic agents has produced conclusive evidence of a beneficial effect (table 2). None of the trials have shown safety concerns for the respective agents, but safety and tolerability will need to be confirmed in subsequent studies. A phase 2 clinical trial of the antiviral favipiravir showed no survival benefit for patients with EVD and with a high viral load (cycle threshold <20), but suggested that further efficacy studies in patients with less advanced disease (cycle threshold ≥20) may be warranted.<sup>50</sup> A trial of the antiviral brincidofovir in Liberia was stopped before a conclusion could be reached after the drug

company withdrew involvement in Ebola trials, in the setting of falling case numbers.<sup>110</sup> A phase 2, single-arm trial of the small interfering RNA lipid nanoparticle compound TKM-130803, done in Sierra Leone, showed no survival advantage in patients with severe EVD, compared with survival in historical (untreated) controls.<sup>109</sup> The Ebola-Tx trial showed no survival benefit in patients who received convalescent plasma compared with historical controls.<sup>71</sup> A separate report of the antibody titres in the transfused plasma found that concentrations of neutralising antibody were generally low and no significant association was found between antibody concentrations in the transfused units and patient survival.<sup>111</sup> A multicentre, randomised trial of the ZMapp triple monoclonal antibody cocktail found that the CFR in patients receiving ZMapp in addition to standard care (22%) was lower than in patients receiving standard of care alone (37%). Although this finding did not meet the prespecified statistical threshold for efficacy, the posterior probability that the addition of ZMapp improved survival was 91%.<sup>108</sup>

Other patients with EVD received experimental therapies on a compassionate basis, outside of clinical trials.<sup>30,57,112,113</sup> Many of these patients were treated in resource-rich countries and received a combination of experimental agents alongside intensive care support and nursing care, so it is difficult to assess safety or efficacy. A small number of patients in west Africa received repurposed agents (including lamivudine, amiodarone, atorvastatin, irbesartan, clomifene, and favipiravir) without enrolment in a registered trial.<sup>114,115</sup> Anecdotal reports of survival benefit have been reported for some of these agents,<sup>114,116</sup> but it is impossible to draw any meaningful conclusions.

A retrospective study of patient outcome data from an ETC in Liberia found a temporal association between the use of antimalarial combination artesunate–amodiaquine and a period of reduced EVD mortality.<sup>117</sup> Patients received this combination when there was a supply failure of the first line agent (artemether–lumefantrine), rather than for hypothesis-driven reasons. This supply failure, along with other limitations described by the authors, makes it difficult to interpret the findings from this study, but additional studies are warranted since in-vitro activity of amodiaquine against Ebola virus provides biological plausibility.<sup>118</sup>

Despite the largely negative outcomes from clinical trials, it must be recognised that the ability of researchers to overcome regulatory and operational barriers to complete trials to internationally accepted standards represents real progress, compared with previous outbreaks caused by high-hazard or emerging pathogens. Several ongoing challenges remain, however. For some drugs, the 100% survival rates seen in non-human primate models<sup>119,120</sup> were not replicated in clinical trials. The reasons underlying these discrepancies should be explored, to maximise the use of the animal model in

	Trial design	Research question (PICO model)	Registration number (declared status as of November, 2016)	Result
ZMapp	Open label RCT with adaptive trial design	Intervention: 50 mg/kg ZMapp, intravenous, every 3 days, total of three doses; comparison with optimised care alone (including favipiravir in Guinea); outcome measured as day 28 survival	Registered as PACTR201503001065306, NCT02363322 (completed)	No statistically conclusive benefit <sup>108</sup>
TKM-130803	Open label, single arm, Component of a multi-stage approach	Intervention: 0.3 mg/kg of TKM-130803, intravenous, once daily, total of seven doses; comparison with historical controls; outcome measured as day 14 survival	Registered as PACTR201501000997429 (completed)	No overall survival benefit <sup>109</sup>
Favipiravir	Open label, single arm	Intervention: 6000 mg (day 0) and 2400 mg (days 1–9), oral, daily of favipiravir, total of ten doses; comparison with historical controls; outcome measured as day 14 survival	Registered as NCT02329054 (completed)	No overall survival benefit <sup>109</sup>
Convalescent plasma	Open label, single arm	Intervention: 400–500 mL of convalescent plasma from two donors, administered as two consecutive (200–250 mL) transfusions; one treatment cycle in total; comparison with historical controls; outcome measured as day 14 survival	Registered as NCT02342171 (completed)	No overall survival benefit <sup>71</sup>
Convalescent plasma	Open label, single arm	Intervention: 180–220 mL of convalescent plasma from two donors, administered as two consecutive (90–110 mL) infusions; up to three treatment cycles, at least 48 h apart; no comparison made; outcome measured as Ebola virus load	Registered as NCT02333578 (recruiting)	NA
Convalescent plasma	Open label, single arm	Intervention: INTERCEPT plasma; dose not defined; comparison not defined; outcome measured as 1 year survival	Registered as NCT02295501 (open to enrolment)	NA
Convalescent plasma	Open label, random allocation	Intervention: single transfusion of convalescent plasma; dose not defined; comparison with Ringer's Lactate solution; outcome measured as all-cause mortality as 14 days after treatment	Registered as ISRCTN13990511 (ongoing; no longer recruiting)	NA
Brincidofovir	Open label, single arm trial, component of a multistage approach	Intervention: 200 mg brincidofovir oral, initial dose, then 100 mg, oral, twice weekly; total of five doses; comparison with historical controls; outcome measured as day 14 survival	Registered as PACTR201411000939962 (recruitment suspended)	No statistical conclusion <sup>110</sup>
Azithromycin, Sunitinib, Erlonitib, Atorvastatin, Irbesartan	Multi-arm RCT with adaptive trial design	Intervention: azithromycin (1500 mg, oral, daily for 5 days) vs sunitinib (50 mg, oral, daily for 7 days) and erlonitib (150 mg, oral, daily for 7 days) vs atorvastatin (40 mg, oral, daily until discharge) and irbesartan (150 mg, oral, daily until discharge); comparison with intravenous fluids and laboratory testing alone; outcome measured as day 14 survival	Registered as NCT02380625 (not yet open to recruitment)	NA
Interferon $\beta$	Open label, single arm	Intervention: subcutaneous interferon $\beta$ once daily for up to 10 days; comparison not defined (safety and effectiveness study); undefined outcome	Registered as ISRCTN17414946 (completed)	NA
Amiodarone	Open label, RCT	Intervention: amiodarone (20 mg/kg, intravenous, on days 1–3 then 200 mg, oral, three times daily, on days 4–10); comparison with supportive care alone; outcome measured as day 10 survival	Registered as NCT02307591 and PACTR201501001014425 (withdrawn)	NA

Where a dose of an intervention has been stated, it refers to the stated adult dose. Refer to trial protocols for weight adjustment. PICO=participant, intervention, comparison, outcome. RCT=randomised controlled trial. NA=not available.

**Table 2: Patient-based clinical trials of experimental therapeutics registered on clinical trial databases during the west Africa Ebola virus disease outbreak**

drug development. Explanations might include inherent biological differences between species, animal models that do not match human illness,<sup>109,121</sup> differences in exposure route and infectious dose, or that some patients present late in the course of illness with complex end-organ manifestations that cannot be simulated completely in an animal model.

### Vaccines

The epidemic also prompted accelerated efforts to take leading vaccine candidates to clinical trials, and to advance preclinical pipelines for less-developed candidates.<sup>122</sup> Overall, four candidate vaccines met WHO criteria for fast-tracked clinical assessment: the replication competent recombinant vesicular stomatitis virus (rVSV) vaccine expressing Zaire Ebola virus glycoprotein (ZEBOV), the replication-deficient chimpanzee adenovirus serotype 3 vector vaccine (ChAd3-ZEBOV), followed later by another

adenoviral vectored vaccine (Ad26-ZEBOV) with a heterologous boost (modified vaccinia virus Ankara, MVA), and a nanoparticle vaccine (Novavax).<sup>123</sup> The first clinical trial in a highly affected country commenced in February, 2015; with the exception of the nanoparticle vaccine, for which the phase 1 trial is ongoing, all of the candidates have been investigated in clinical trials in the region (table 3).

The phase 3 *Ebola ça suffit* rVSV-ZEBOV trial done in Guinea yielded remarkable interim findings.<sup>124</sup> This study used a novel approach of ring vaccination, a method that was first used during smallpox eradication programmes and involves vaccination of high-risk contacts (defined geographically or socially) of known EVD cases, with the aim of interrupting transmission. Rings of contacts received either immediate or delayed (21 days postexposure) vaccination in a cluster randomised trial. This pragmatic approach aimed to balance the

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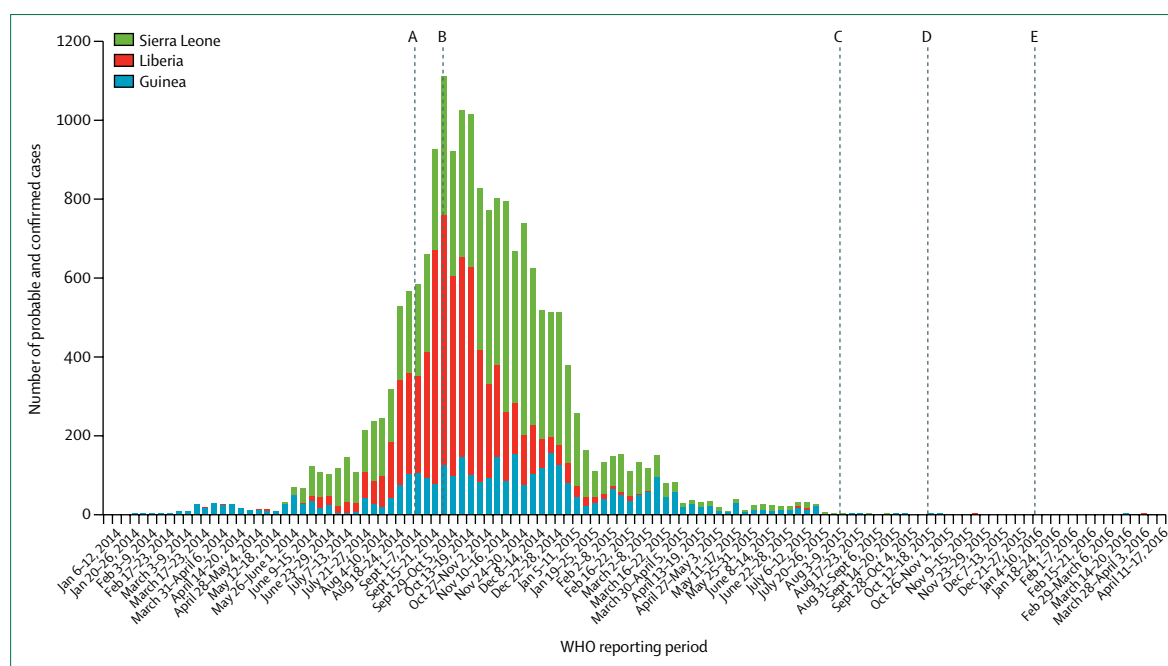
	Trial design	Research question (PICO model)	Registration number (declared status as of November, 2016)
<b>rVSV ZEBOV</b>			
Ebola ça suffit!	Open label, cluster randomised, ring vaccination	Participants include contacts of confirmed EVD patients; intervention with immediate vaccination with rVSV ZEBOV; comparison with delayed (day 21) vaccination; outcome measured as safety and efficacy	Registered as PACTR201503001057193 (interim results available <sup>124</sup> )
Ebola ça suffit!	Open label, single arm	Participants include adult front-line workers; intervention with immediate vaccination with rVSV ZEBOV; comparison with delayed (day 21) vaccination; outcome measured as safety and efficacy	Registered as PACTR201503001057193 (closed to recruitment, follow up complete <sup>125</sup> )
STRIVE	Open label, randomised, with two substudies	Participants include adult front-line workers; intervention with immediate vaccination with vVSV ΔG ZEBOV; comparison with delayed (18–24 weeks) vaccination; outcomes measured as safety, efficacy, and immunogenicity	Registered as NCT02378753, PACTR201502001037220 (ongoing but not recruiting)
<b>Multiple</b>			
PREVAC	Double-blind RCT	Participants include children and adults; intervention with immediate vaccination with rVSV-ZEBOV (with or without rVSV boost) or Ad26.ZEBOV + MVA-BN-Filo boost; comparison with placebo; outcomes measured as safety and immunogenicity	Registered as NCT02876328 (not yet open for recruitment)
PREVAIL	Double-blind RCT	Participants include adults with Ebola virus infection; intervention with immediate vaccination with VSVG-ZEBOV or ChAd3-EBO Z; comparison with placebo; outcomes measured as safety and immunogenicity	Registered as NCT02344407 (ongoing, but not recruiting, no results available)
<b>Ad5-EBOV</b>			
Ad5-EBOV	Double-blind RCT	Participants include healthy adults aged 18–50 years in Sierra Leone; intervention with high dose, or low dose immediate vaccination with Ad5-EBOV; comparison with placebo; outcome measured as safety and immunogenicity	Registered as NCT02575456, PACTR201509001259869 (completed, no results available)
<b>Ad26. ZEBOV + MVA-BN-Filo</b>			
EBOVAC	Open label, single arm, followed by double-blind RCT	Participants include healthy adults and children in Sierra Leone; intervention with immediate vaccination with Ad26-ZEBOV and with MVA-BN-Filo boost; comparison with placebo (meningococcal vaccine during immediate vaccination) during the second stage of the RCT; outcome measured as safety, immunogenicity, and efficacy	Registered as NCT02509494, PACTR201506001147964 (recruiting)
EVD=Ebola virus disease. PICO=participant, intervention, comparison, outcome. RCT=randomised controlled trial.			
<b>Table 3: Vaccine trials recruiting in the most affected countries during the Ebola virus disease outbreak in west Africa</b>			

requirement for high-quality efficacy and safety data against ethical concerns about using placebo designs in highly susceptible populations in the midst of an EVD outbreak.<sup>126</sup> Preliminary results suggest excellent efficacy (100%, 95% CI 75–100). There were no new infections after 6 days in participants that were immediately vaccinated (n=2014), compared with 16 infections in the delayed vaccination group (n=1930).<sup>124</sup> In light of these findings, randomisation was stopped and all subsequent participants received immediate vaccination. Concerns have been raised about the reactogenicity of rVSV-ZEBOV following observed, transient fever (up to 30%), arthritis (3–22%), rash, and dermatitis in phase 1 trials in Africa and Europe.<sup>127</sup> Whether these findings apply to other populations is unknown, as is the effect of potential side-effects on the acceptability of the vaccine among individuals at varying levels of risk of EVD. A substantial practical challenge to rolling out this vaccine in an outbreak would be differentiating those with transient

vaccine-related fever from those who are developing symptomatic EVD. Additionally, the transient viraemia triggered by vaccination could also result in a false-positive PCR result with some tests.<sup>128</sup>

Adenovirus vector vaccines were the second type of vaccine to reach clinical trials in the affected countries. Phase 1/2a trials of ChAd3-ZEBOV showed safety.<sup>129–131</sup> However, a trial with study groups in the USA and Mali showed that a single dose of vaccine elicited sufficient immunogenicity likely to be effective in postexposure prophylaxis scenarios, but that a heterologous prime and boost (with modified vaccinia Ankara expressing Zaire Ebola virus glycoprotein) would be more appropriate when an extended period of protection was required.<sup>129</sup> The superior protective efficacy of a heterologous prime-boost regimen has been shown in other phase 1 trials of ChAd3<sup>132</sup> and Ad26-ZEBOV<sup>133</sup> and, in practical terms, might make it important for groups who have prolonged exposure periods—eg, health-care workers





**Figure: Significant research advances during west Africa Ebola virus disease epidemic**

Adapted from Bausch and Rojek (2016).<sup>134</sup> (A) WHO holds consultation on potential Ebola therapeutics and vaccines.<sup>135</sup> (B) WHO Response Team publishes first large observational patient data set.<sup>13</sup> (C) Interim results of VSV-ZEBOV vaccine trial published.<sup>124</sup> (D) Molecular evidence for sexual transmission published.<sup>104</sup> (E) First clinical trial of experimental treatment (convalescent plasma) published.<sup>71</sup>

and burial teams.<sup>129</sup> As we learn more about viral sequestration and sexual transmission, more durable vaccine-induced immunity might be required to provide longer-term protection of sexual partners or survivors of EVD. However, the inclusion of a boosting component will add to the logistical complexity of mass vaccination. The results of field trials of adenovirus vector-based vaccines are awaited (table 3).

Other ongoing vaccination trials in the region commenced too late to identify effectiveness. However, they should be able to provide important safety and immunogenicity data, including comparative data for different candidate vaccines. This presents a dilemma with respect to licensure of these vaccines. Although it is possible that promising Ebola vaccines could receive regulatory approval if human safety and immunogenicity data are supported by evidence of efficacy in non-human primate studies, the limitations of the present animal model and an imprecise understanding of immune correlates of protection mean there is little certainty in this process. The ongoing development and assessment of different vaccines are important, because it is unlikely that a single vaccine will meet all of the criteria in the WHO target therapeutic profile.<sup>123</sup>

## Conclusions

There have been several notable successes in the scientific response to this epidemic, including improved characterisation of EVD complications and the completion of clinical trials of experimental therapeutics

(figure). Progress was slow in other areas. Despite the large number of patients, the reporting of clinical manifestations was fragmented and many published studies have described small cohorts or single cases. Data collection was frequently ad hoc or retrospective, highlighting the need to embed clinically relevant research in outbreak preparedness and response. Knowledge of how EVD affects susceptible populations, such as pregnant women and children, has not progressed substantially. We do not know the true benefits (or potential harms) of administering specific components of supportive care. Reporting on the outcomes of patients treated in resource-rich countries has been descriptive and repetitive, and only one medically evacuated patient was recruited to a clinical trial.

An important question is how to apply findings from studies that have generated new information, particularly when the results are inconclusive. For example, despite the absence of incontrovertible evidence of efficacy, it is possible that ZMapp will be included as standard of care in future EVD outbreaks; if this happens, it is likely that trials of any new agents will need to show superiority of the new agent given alongside ZMapp, compared with ZMapp alone. Such trials will also need to stratify by viral load on admission.<sup>73</sup>

Individual components of supportive care interventions have not been assessed in EVD-specific trials. The rationale of providing intravenous fluid replacement to patients with substantial gastrointestinal fluid losses is clear, but there is scope to compare different empirical

### Search strategy and selection criteria

We searched PubMed for articles published from the beginning of the west Africa outbreak on Jan 1, 2014, to Nov 30, 2016, using search terms “Ebola” or “Ebola virus” or “Ebola Virus Disease” or “Ebola Haemorrhagic Fever” using British and American spelling variations. We reviewed the articles from the search that had an abstract available in English in addition to relevant references cited in those articles and conference and international meeting reports. We reviewed all publications that contained original research or patient data for quality and relevance. To identify ongoing unpublished clinical research, we searched clinical trial databases ClinicalTrials.gov, the Pan African Clinical Trials Registry, and the ISRCTN registry.

Two authors (AR, JD) categorised all papers according to predefined subject area, using publication review software (appendix). There were no discrepancies in individual categorisation that required mediation from the third author (PH). Papers were selected for inclusion on the basis of clinical relevance by joint review of two authors (AR, JD). A few papers that were published before the outbreak were included where comparison with existing knowledge was considered necessary; these were identified from the libraries of the authors.

fluid replacement regimens and investigate the optimal timing of fluid replacement. Although the observational studies of patients treated in Europe and the USA suggest that physiological support does contribute to survival, many of the advanced interventions used will be difficult to translate to the typical ETC environment and so a key component of assessment will be feasibility and practicality.

For pharmaceutical interventions that could alter the course of future outbreaks, the greatest hope comes from the *Ebola ça suffit!* ring vaccination trial. The final results from this trial<sup>136</sup> were published after the literature search for this Review, and the results confirm the highly promising interim findings.<sup>124</sup> It is likely that ring vaccination strategies will be adopted in future outbreaks caused by Zaire Ebola virus strains.

Additional findings from the west Africa epidemic are expected and it is hoped that new data will contribute to the knowledge base. The degree to which findings from this epidemic can be applied to future outbreaks, including those caused by different species of Ebola virus, is unknown; a comparison of key clinical findings from different outbreaks would be useful, but would rely on high-quality, comparable datasets being available. Future, smaller EVD outbreaks can be expected in at-risk countries and clinical studies will need to be rapid and efficient; greater yields may be obtained if research priorities are agreed in advance, with centralised coordination of studies.

In all of the fields reviewed, we have discussed areas of priority for future investigation. To achieve the most

rigorous outcomes from future studies, there must be an improved commitment to producing protocol-directed, hypothesis-driven research whenever possible. When this is infeasible, recommendations should be based on careful, systematic data collection and use of shared platforms that facilitate data collation across different sites. This data collation will require not only a commitment from scientists but also funding and publishing mechanisms that facilitate and reward collaborative science.

### Contributors

AR performed the literature search, according to the stated search strategy. AR, PH, and JD reviewed and selected articles to include in the Review, based on the stated selection criteria. AR produced the figures and tables. All authors contributed to writing the Review.

### Declaration of interests

We declare no competing interests. The authors were investigators for two clinical trials described in this Review (TKM-130803 and brincidofovir trials).

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From: Coffey, Georgia </o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b) (5)>  
To: (b) (6) </o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b) (5)>  
Cc: (b) (6) (VACO) </o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b) (5)> (b) (6)  
</o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)> Wagner,  
John (Wolf) </o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> (b) (6)  
(VA) </o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> Wright,  
Vivieca (Simpson) </o=va/ou=va  
martinsburg/cn=recipients/cn=(b) (6), (b) (5)> Ulyot, John  
</o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> Blackburn,  
Scott R. </o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> Shulkin, David  
J., MD </o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)> Shelby, Peter  
J. </o=va/ou=exchange administrative group  
(fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (5)>  
Bcc:  
Subject: RE: Message on Charlottesville from Chief Diversity Officer  
Date: Fri Aug 18 2017 14:16:07 CDT  
Attachments: image001.jpg  
image003.png  
image004.jpg

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This is very unfortunate. Other agencies have already posted such messages to their workforce (Dept of Education for one). My role as Chief Diversity Officer is to advise the Secretary and provide policy guidance on all matters related to EEO, diversity and inclusion that affect the VA. This national issue, clearly impacts the VA as evidenced by the numerous inquiries and concerns I've received on this. I respect the Secretary's decision if he chooses not to issue the message we drafted for his consideration. However, the message below is mine and consistent with my responsibility as the Chief Diversity Officer of VA to assure our employees of our commitment to EEO and diversity in accordance with law and VA policy. I look forward to speaking with our leadership about this.

Georgia Coffey

Deputy Assistant Secretary for Diversity and Inclusion

U.S. Department of Veterans Affairs

202-461-4131

Visit our Web site: [www.diversity.va.gov](http://www.diversity.va.gov)

Please provide us feedback on our services:

<https://survey.htm.va.gov/Perseus/se/7FDA9EA774D03B42>.

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From: (b) (6)  
Sent: Friday, August 18, 2017 3:06 PM  
To: Coffey, Georgia  
Cc: (b) (6) (VACO); (b) (6); Wagner, John (Wolf); (b) (6) (VA)  
Subject: FW: Message on Charlottesville from Chief Diversity Officer  
Importance: High

Georgia,

OPIA Assistant Secretary John Ulliot does not want to post the message, as the Secretary previously made statements in the news media on this topic earlier this week. Please see the below message from John "Wolf" Wagner, OPIA Principal Deputy Assistant Secretary. If you have questions, please feel free to reach out to Wolf or John Ulliot.

Thanks.

(b) (6)

From: Wagner, John (Wolf)  
Sent: Friday, August 18, 2017 2:43 PM  
To: (b) (6)  
Cc: Hutton, James; (b) (6) (VA); Ulliot, John  
Subject: Re: Message on Charlottesville from Chief Diversity Officer  
Importance: High

(b) (6)

Just spoke with John. We're not going to post anything on this. The SecVA spoke at length on this this week and there are numerous articles in the press regarding his remarks.

Thanks!

John 'Wolf' Wagner

Principal Deputy Assistant Secretary

Public and Intergovernmental Affairs

U.S. Department of Veterans Affairs

O: 202-461-7500

john.wolf.wagner@va.gov

From: (b) (6) <(b) (6)@va.gov>  
Date: Friday, August 18, 2017 at 1:23 PM  
To: Department of Veterans Affairs Department of Veterans Affairs <john.wolf.wagner@va.gov>  
Cc: "Hutton, James" <James.Hutton@va.gov>, (b) (6) (VA)" <(b) (6)@va.gov>  
Subject: Message on Charlottesville from Chief Diversity Officer

Wolf,

Please see below for the message that Georgia Coffey, VA's Chief Diversity Officer, would like to post to the internal blog, as well as HeyVA and VACO Daily News. As you can see in the email string below, she also is seeking approval from the Chief of Staff on this.

(b) (6)

From: Coffey, Georgia  
Sent: Friday, August 18, 2017 11:53 AM  
To: Wright, Vivieca (Simpson)  
Cc: (b) (6) (VACO); Ulliyot, John; (b) (6) (VACO); (b) (6); Shelby, Peter J.; (b) (6)  
Subject: FW: VACO Daily News/HEY VAs  
Importance: High

Vivieca,

I understand you are out of the office today however I have been advised to reach out to you directly on this time-sensitive matter. We are seeking your approval to post the message below on Hey VA and other VA news outlets to address the recent events in Charlottesville. We have the ASHRA's consent and are simultaneously clearing this with OPIA. We have also sent the SecVA a draft all-employee message in VAIQ for his consideration and personal dissemination. As im sure you'll understand, we believe it is important for VA to issue a message to our employees denouncing the acts of bigotry and reaffirming our commitment to equity, diversity, and inclusion in VA. Several employees have expressed this to me personally. I am respectfully requesting your expedited approval of the message below for issuance soonest. Thank you in advance.

Georgia Coffey

Deputy Assistant Secretary for Diversity and Inclusion

U.S. Department of Veterans Affairs

202-461-4131

Visit our Web site: [www.diversity.va.gov](http://www.diversity.va.gov)

Please provide us feedback on our services:

<https://survey.htm.va.gov/Perseus/se/7FDA9EA774D03B42>.

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From: Coffey, Georgia

Sent: Friday, August 18, 2017 10:44 AM

To: (b) (6)

Cc: (b) (6) (VACO); Shelby, Peter J.; (b) (6)

Subject: RE: VACO Daily News/HEY VAs

(b) (6) if it's not too late, the Assistant Secretary for HRA, Peter Shelby, would like the language in red below to be added to the 1st paragraph of the VA-wide Broadcast Message. Please advise when this message will go out> Thank you in advance.

## MESSAGE FROM VA'S CHIEF DIVERSITY OFFICER

This past week, Americans were shocked by horrific events in Charlottesville, Virginia that were an assault on our Nation's defining values of diversity and inclusion. The repugnant display of hate and bigotry by white supremacists, neo-Nazis, and the Ku Klux Klan do not represent America, but serve as a tragic reminder that our work in civil rights and inclusion is not finished. The Secretary of Veterans Affairs (VA), the Assistant Secretary for Human Resources and Administration, and I join the growing chorus of universal condemnation of these misguided acts of intolerance by a marginalized few.

As VA's Chief Diversity Officer, I want to assure our employees that we in VA unequivocally reject and condemn the actions of these individuals and stand strong in our commitment to equal opportunity, diversity, and full inclusion for all in VA and beyond. To that point, I ask each of you to promote and model the principles and protections contained in the Secretary's recently issued Equal Employment Opportunity, Diversity and Inclusion, No FEAR, and Whistleblower Rights and Protection Policy Statement available at [https://www.diversity.va.gov/policy/files/EEO\\_Policy\\_Statement.pdf](https://www.diversity.va.gov/policy/files/EEO_Policy_Statement.pdf). Please join us in our unwavering commitment to equity, diversity and inclusion in service to our Nation's Veterans. Thank you.

Georgia Coffey

Georgia Coffey

Deputy Assistant Secretary for Diversity and Inclusion

U.S. Department of Veterans Affairs

202-461-4131

Visit our Web site: [www.diversity.va.gov](http://www.diversity.va.gov)

Please provide us feedback on our services:

<https://survey.htm.va.gov/Perseus/se/7FDA9EA774D03B42>.

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From: (b) (6)  
Sent: Thursday, August 17, 2017 3:28 PM  
To: (b) (6)  
Cc: Coffey, Georgia; (b) (6) (VACO)  
Subject: RE: VACO Daily News/HEY VAs

(b) (6)

Here is Georgia's message (below) and photo (attached). I will be out of the office for the next week beginning this afternoon so your contact if needed will be (b) (6) (copied).

#### MESSAGE FROM VA'S CHIEF DIVERSITY OFFICER

This past week, Americans were shocked by horrific events in Charlottesville, Virginia that were an assault on our Nation's defining values of diversity and inclusion. The repugnant display of hate and bigotry by white supremacists, neo-Nazis, and the Ku Klux Klan do not represent America, but serve as a tragic reminder that our work in civil rights and inclusion is not finished. The Secretary of Veterans Affairs (VA) and I join the growing chorus of universal condemnation of these misguided acts of intolerance by a marginalized few.

As VA's Chief Diversity Officer, I want to assure our employees that we in VA unequivocally reject and condemn the actions of these individuals and stand strong in our commitment to equal opportunity, diversity, and full inclusion for all in VA and beyond. To that point, I ask each of you to promote and model the principles and protections contained in the Secretary's recently issued Equal Employment Opportunity, Diversity and Inclusion, No FEAR, and Whistleblower Rights and Protection Policy Statement available at [https://www.diversity.va.gov/policy/files/EEO\\_Policy\\_Statement.pdf](https://www.diversity.va.gov/policy/files/EEO_Policy_Statement.pdf). Please join us in our unwavering commitment to equity, diversity and inclusion in service to our Nation's Veterans. Thank you.

Georgia Coffey

Thank you,

(b) (6)  
Office of Diversity & Inclusion  
U.S. Department of Veterans Affairs  
(202) 461-(b) (6)  
<https://www.diversity.va.gov>

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any email and any printout thereof.

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From: (b) (6)  
Sent: Thursday, August 17, 2017 11:23 AM  
To: (b) (6)  
Subject: RE: VACO Daily News/HEY VAs

(b) (6)

I'm sorry I'm just getting back to you. I just got in from appointments.

We can get this on VACO News and our national HEY VAs, and the word limit for that is 200 words max.

I usually send them out a week ahead and normally on Thursdays. However, as this is such a critical issue, I can hold on those for a bit, if you think the remarks could be submitted before end of business today.

Also, if you have a good photo we can use -- of Georgia or something diversity-related, even a graphic (approx. 730 wide by 370 in height) -- I can take her remarks and get them on the blog (formerly MyVA, but now named VA NEWS <https://myva.va.gov/blog>), I would like to see it in our Top Stories on there as well.

Thanks!

(b) (6)

Public Affairs Specialist

Office of Public & Intergovernmental Affairs

(b) (6) @va.gov

Follow me on VA Pulse!

Don't miss out – check out the latest VA employee news today on MyVA NEWS.

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Owner: Coffey, Georgia </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)  
Filename: image001.jpg  
Last Modified: Fri Aug 18 14:16:07 CDT 2017

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image001

for Print

Item: 60

Attachme

of 3)



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Owner: Coffey, Georgia </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6), (b) (5)  
Filename: image003.png  
Last Modified: Fri Aug 18 14:16:07 CDT 2017

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image003.png for Printed Item: 60 ( Attachment 2 of 3)

**VIA**  
AMERICAN  
OVERSIGHT



U.S. Department  
of Veterans Affairs

VA-17-0334-A-00003224

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From: (b) (6), (b) (7)(C) . EOP/WHO  
<(b) (6), (b) (7)(C) @who.eop.gov>  
To: DJS </o=va/ou=exchange administrative  
group (fydibohf23spdlt)/cn=recipients/cn=(b) (6),  
(b) (6), (b) (7)(C) . EOP/WHO  
<(b) (6), (b) (7)(C) @who.eop.gov>  
Bcc:  
Subject: [EXTERNAL] Re: Not urgent- A few thoughts  
Date: Sat Aug 12 2017 19:26:38 CDT  
Attachments:

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Secretary

(b) (5)

Thanks

(b) (6), (b) (7)(C)

Sent from my iPhone

> On Aug 12, 2017, at 20:00, DJS <vacodjs1@va.gov> wrote:

>

> (b) (6), (b) (7)(C) (b) (5)

We missed each other at Bedminster today. We had a great signing event this afternoon though it was overshadowed by the tragic events in Charlottesville. Most outlets did not report on the bipartisan legislation passed for veterans- but it's certainly understandable.

>

> (b) (5)

>

> (b) (5)

>

>

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(b) (5)

>

> Thanks

>

> David Shulkin

>

>

>

> Sent with Good (>www.good.com<)

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From: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6), (b) (6), (b) (6), (b) (7)(C)@who.eop.gov>  
To: (b) (6), (b) (6), (b) (7)(C)  
Cc:  
Bcc:  
Subject: Not urgent- A few thoughts  
Date: Sat Aug 12 2017 19:00:19 CDT  
Attachments:

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(b) (6), (b) (7)(C) (b) (5)

We missed each other at Bedminster today. We had a great signing event this afternoon though it was overshadowed by the tragic events in Charlottesville. Most outlets did not report on the bipartisan legislation passed for veterans- but it's certainly understandable.

(b) (5)

(c) (6) (c) (7)(C)

Thanks

David Shulkin

Sent with Good ([www.good.com](http://www.good.com))